

5617

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	c. LENGTH OF STAY IN lb <u>all his life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>602 Liberty St.</u>		d. STREET ADDRESS <u>602 Liberty St.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE HOFF ANDERS</u>		4. DATE OF DEATH Month Day Year <u>MAY 3 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 8 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>81</u>
11. BIRTHPLACE (State or foreign country) <u>Westminster</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Mitter</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Hoff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>J. Thomas Anders</u>		Address <u>Same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic Poisoning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio-renal-vascular disease</u> DUE TO (c) <u>Senility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>3 years</u> <u>Several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1<sup>st</sup></u> , 1955, to <u>May 3<sup>rd</sup></u> , 1960, that I last saw the deceased alive on <u>May 1<sup>st</sup></u> , 1960, and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>C. L. Billingslea</u> M.D. <u>Westminster, Md 5-3-60</u> PHYSICIAN'S NAME (Type) <u>C. L. Billingslea</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5/5/60</u>	<u>Westminster, County Westminster, Md</u>	<u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>		ADDRESS <u>Westminster, Md</u>	24a. REC'D BY REGISTRAR DATE <u>MAY 5 '60</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. **STATE DEPARTMENT OF HEALTH—BARTON**

1992

5622

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster 50yr</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster RD#4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hook Road</u>				d. STREET ADDRESS <u>Hook Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>A.</u> Last <u>ARNOLD</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 11, 1870</u>		9. AGE (In years last birthday) <u>89</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Arnold</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Brothers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>Mrs Dorothy A. Luster, Westminster</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis (chr) Nephrosis (cc)</u> <u>421.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Uremia</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 1960</u> to <u>May 30, 1960</u> , that I last saw the deceased alive on <u>May 29, 1960</u> , and that death occurred at <u>5-2</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm C. Jernette</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>103 E Main Westminster Md.</u> <u>5-23-60</u>			
PHYSICIAN'S NAME (Type) <u>Wm C. Jernette M.D.</u>				<u>Westminster Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 1 1960</u>		<u>Deer Park Cemetery Rural Westminster Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneub</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

5623

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAUDE NAOMI BARNES</u>				4. DATE OF DEATH Month Day Year <u>MAY 13 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 18-1879</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>EXRA FAENGLE</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE HOLLENBERY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-10-5410B</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>immediate</u>				18. INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/1/60</u> , 19 <u>60</u> to <u>5/13/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5/13/60</u> , 19 <u>60</u> , and that death occurred at <u>4:50 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M.E. Robertson</u>				ADDRESS (Street, city or town, state) <u>New Windsor Md 5/14/60</u>			
PHYSICIAN'S NAME (Type) <u>M.E. ROBERTSON</u>				DATE SIGNED <u>NEW WINDSOR MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>5/16/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEM.</u>				22d. LOCATION (City, town, or county) (State) <u>UNIONTOWN MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>D.D. Hartzler</u>				ADDRESS <u>UNION BRIDGE MD</u>			
24a. REC'D BY REGISTRAR <u>MAY 17 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hartzler</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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IN SENATE  
January 12, 1904

REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1899

ALBANY:  
J. B. LIPPINCOTT & CO. PRINTERS  
1904

5624

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Taneytown, Md.</u>	
c. LENGTH OF STAY IN 1b <u>3 yrs.</u>		d. STREET ADDRESS <u>Route #1 Bowers Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route #1, Taneytown, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>August</u> Middle <u>Berkemeier</u> Last <u>Berkemeier</u>		4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1882</u>
9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clerk Baltio. City Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Berkemeier</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Seibert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>220-36-5060</u>	
17. INFORMANT <u>Taneytown, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>49 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Mar 19</u> , 19 <u>60</u> , to <u>5/8/60</u> , 19____, that I last saw the deceased alive on <u>5/6/60</u> , 19____, and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>M. E. Robertson M.D.</u> M.D. <u>New Windsor, Md.</u> <u>5/8/60</u> PHYSICIAN'S NAME (Type) <u>M. E. Robertson, M.D.</u> <u>New Windsor, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 11, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 11 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. H. H.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1234

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of anatomist	
22. Signature of surgeon		23. Signature of dentist		24. Signature of pharmacist	
25. Signature of nurse		26. Signature of hospital		27. Signature of doctor	
28. Signature of family		29. Signature of friends		30. Signature of neighbors	
31. Signature of community		32. Signature of country		33. Signature of world	
34. Signature of universe		35. Signature of God		36. Signature of Jesus	
37. Signature of Mary		38. Signature of John		39. Signature of Peter	
40. Signature of Paul		41. Signature of James		42. Signature of Matthew	
43. Signature of Mark		44. Signature of Luke		45. Signature of John	
46. Signature of Andrew		47. Signature of Thomas		48. Signature of Philip	
49. Signature of Bartholomew		50. Signature of Matthew		51. Signature of James	
52. Signature of John		53. Signature of Peter		54. Signature of Paul	
55. Signature of James		56. Signature of Matthew		57. Signature of Mark	
58. Signature of Luke		59. Signature of John		60. Signature of Andrew	
61. Signature of Thomas		62. Signature of Philip		63. Signature of Bartholomew	
64. Signature of Matthew		65. Signature of James		66. Signature of John	
67. Signature of Peter		68. Signature of Paul		69. Signature of James	
70. Signature of Matthew		71. Signature of Mark		72. Signature of Luke	
73. Signature of John		74. Signature of Andrew		75. Signature of Thomas	
76. Signature of Philip		77. Signature of Bartholomew		78. Signature of Matthew	
79. Signature of James		80. Signature of John		81. Signature of Peter	
82. Signature of Paul		83. Signature of James		84. Signature of Matthew	
85. Signature of Mark		86. Signature of Luke		87. Signature of John	
88. Signature of Andrew		89. Signature of Thomas		90. Signature of Philip	
91. Signature of Bartholomew		92. Signature of Matthew		93. Signature of James	
94. Signature of John		95. Signature of Peter		96. Signature of Paul	
97. Signature of James		98. Signature of Matthew		99. Signature of Mark	
100. Signature of Luke		101. Signature of John		102. Signature of Andrew	
103. Signature of Thomas		104. Signature of Philip		105. Signature of Bartholomew	
106. Signature of Matthew		107. Signature of James		108. Signature of John	
109. Signature of Peter		110. Signature of Paul		111. Signature of James	
112. Signature of Matthew		113. Signature of Mark		114. Signature of Luke	
115. Signature of John		116. Signature of Andrew		117. Signature of Thomas	
118. Signature of Philip		119. Signature of Bartholomew		120. Signature of Matthew	
121. Signature of James		122. Signature of John		123. Signature of Peter	
124. Signature of Paul		125. Signature of James		126. Signature of Matthew	
127. Signature of Mark		128. Signature of Luke		129. Signature of John	
130. Signature of Andrew		131. Signature of Thomas		132. Signature of Philip	
133. Signature of Bartholomew		134. Signature of Matthew		135. Signature of James	
136. Signature of John		137. Signature of Peter		138. Signature of Paul	
139. Signature of James		140. Signature of Matthew		141. Signature of Mark	
142. Signature of Luke		143. Signature of John		144. Signature of Andrew	
145. Signature of Thomas		146. Signature of Philip		147. Signature of Bartholomew	
148. Signature of Matthew		149. Signature of James		150. Signature of John	
151. Signature of Peter		152. Signature of Paul		153. Signature of James	
154. Signature of Matthew		155. Signature of Mark		156. Signature of Luke	
157. Signature of John		158. Signature of Andrew		159. Signature of Thomas	
160. Signature of Philip		161. Signature of Bartholomew		162. Signature of Matthew	
163. Signature of James		164. Signature of John		165. Signature of Peter	
166. Signature of Paul		167. Signature of James		168. Signature of Matthew	
169. Signature of Mark		170. Signature of Luke		171. Signature of John	
172. Signature of Andrew		173. Signature of Thomas		174. Signature of Philip	
175. Signature of Bartholomew		176. Signature of Matthew		177. Signature of James	
178. Signature of John		179. Signature of Peter		180. Signature of Paul	
181. Signature of James		182. Signature of Matthew		183. Signature of Mark	
184. Signature of Luke		185. Signature of John		186. Signature of Andrew	
187. Signature of Thomas		188. Signature of Philip		189. Signature of Bartholomew	
190. Signature of Matthew		191. Signature of James		192. Signature of John	
193. Signature of Peter		194. Signature of Paul		195. Signature of James	
196. Signature of Matthew		197. Signature of Mark		198. Signature of Luke	
199. Signature of John		200. Signature of Andrew		201. Signature of Thomas	
202. Signature of Philip		203. Signature of Bartholomew		204. Signature of Matthew	
205. Signature of James		206. Signature of John		207. Signature of Peter	
208. Signature of Paul		209. Signature of James		210. Signature of Matthew	
211. Signature of Mark		212. Signature of Luke		213. Signature of John	
214. Signature of Andrew		215. Signature of Thomas		216. Signature of Philip	
217. Signature of Bartholomew		218. Signature of Matthew		219. Signature of James	
220. Signature of John		221. Signature of Peter		222. Signature of Paul	
223. Signature of James		224. Signature of Matthew		225. Signature of Mark	
226. Signature of Luke		227. Signature of John		228. Signature of Andrew	
229. Signature of Thomas		230. Signature of Philip		231. Signature of Bartholomew	
232. Signature of Matthew		233. Signature of James		234. Signature of John	
235. Signature of Peter		236. Signature of Paul		237. Signature of James	
238. Signature of Matthew		239. Signature of Mark		240. Signature of Luke	
241. Signature of John		242. Signature of Andrew		243. Signature of Thomas	
244. Signature of Philip		245. Signature of Bartholomew		246. Signature of Matthew	
247. Signature of James		248. Signature of John		249. Signature of Peter	
250. Signature of Paul		251. Signature of James		252. Signature of Matthew	
253. Signature of Mark		254. Signature of Luke		255. Signature of John	
256. Signature of Andrew		257. Signature of Thomas		258. Signature of Philip	
259. Signature of Bartholomew		260. Signature of Matthew		261. Signature of James	
262. Signature of John		263. Signature of Peter		264. Signature of Paul	
265. Signature of James		266. Signature of Matthew		267. Signature of Mark	
268. Signature of Luke		269. Signature of John		270. Signature of Andrew	
271. Signature of Thomas		272. Signature of Philip		273. Signature of Bartholomew	
274. Signature of Matthew		275. Signature of James		276. Signature of John	
277. Signature of Peter		278. Signature of Paul		279. Signature of James	
280. Signature of Matthew		281. Signature of Mark		282. Signature of Luke	
283. Signature of John		284. Signature of Andrew		285. Signature of Thomas	
286. Signature of Philip		287. Signature of Bartholomew		288. Signature of Matthew	
289. Signature of James		290. Signature of John		291. Signature of Peter	
292. Signature of Paul		293. Signature of James		294. Signature of Matthew	
295. Signature of Mark		296. Signature of Luke		297. Signature of John	
298. Signature of Andrew		299. Signature of Thomas		300. Signature of Philip	
301. Signature of Bartholomew		302. Signature of Matthew		303. Signature of James	
304. Signature of John		305. Signature of Peter		306. Signature of Paul	
307. Signature of James		308. Signature of Matthew		309. Signature of Mark	
310. Signature of Luke		311. Signature of John		312. Signature of Andrew	
313. Signature of Thomas		314. Signature of Philip		315. Signature of Bartholomew	
316. Signature of Matthew		317. Signature of James		318. Signature of John	
319. Signature of Peter		320. Signature of Paul		321. Signature of James	
322. Signature of Matthew		323. Signature of Mark		324. Signature of Luke	
325. Signature of John		326. Signature of Andrew		327. Signature of Thomas	
328. Signature of Philip		329. Signature of Bartholomew		330. Signature of Matthew	
331. Signature of James		332. Signature of John		333. Signature of Peter	
334. Signature of Paul		335. Signature of James		336. Signature of Matthew	
337. Signature of Mark		338. Signature of Luke		339. Signature of John	
340. Signature of Andrew		341. Signature of Thomas		342. Signature of Philip	
343. Signature of Bartholomew		344. Signature of Matthew		345. Signature of James	
346. Signature of John		347. Signature of Peter		348. Signature of Paul	
349. Signature of James		350. Signature of Matthew		351. Signature of Mark	
352. Signature of Luke		353. Signature of John		354. Signature of Andrew	
355. Signature of Thomas		356. Signature of Philip		357. Signature of Bartholomew	
358. Signature of Matthew		359. Signature of James		360. Signature of John	
361. Signature of Peter		362. Signature of Paul		363. Signature of James	
364. Signature of Matthew		365. Signature of Mark		366. Signature of Luke	
367. Signature of John		368. Signature of Andrew		369. Signature of Thomas	
370. Signature of Philip		371. Signature of Bartholomew		372. Signature of Matthew	
373. Signature of James		374. Signature of John		375. Signature of Peter	
376. Signature of Paul		377. Signature of James		378. Signature of Matthew	
379. Signature of Mark		380. Signature of Luke		381. Signature of John	
382. Signature of Andrew		383. Signature of Thomas		384. Signature of Philip	
385. Signature of Bartholomew		386. Signature of Matthew		387. Signature of James	
388. Signature of John		389. Signature of Peter		390. Signature of Paul	
391. Signature of James		392. Signature of Matthew		393. Signature of Mark	
394. Signature of Luke		395. Signature of John		396. Signature of Andrew	
397. Signature of Thomas		398. Signature of Philip		399. Signature of Bartholomew	
400. Signature of Matthew		401. Signature of James		402. Signature of John	
403. Signature of Peter		404. Signature of Paul		405. Signature of James	
406. Signature of Matthew		407. Signature of Mark		408. Signature of Luke	
409. Signature of John		410. Signature of Andrew		411. Signature of Thomas	
412. Signature of Philip		413. Signature of Bartholomew		414. Signature of Matthew	
415. Signature of James		416. Signature of John		417. Signature of Peter	
418. Signature of Paul		419. Signature of James		420. Signature of Matthew	
421. Signature of Mark		422. Signature of Luke		423. Signature of John	
424. Signature of Andrew		425. Signature of Thomas		426. Signature of Philip	
427. Signature of Bartholomew		428. Signature of Matthew		429. Signature of James	
430. Signature of John		431. Signature of Peter		432. Signature of Paul	
433. Signature of James		434. Signature of Matthew		435. Signature of Mark	
436. Signature of Luke		437. Signature of John		438. Signature of Andrew	
439. Signature of Thomas		440. Signature of Philip		441. Signature of Bartholomew	
442. Signature of Matthew		443. Signature of James		444. Signature of John	
445. Signature of Peter		446. Signature of Paul		447. Signature of James	
448. Signature of Matthew		449. Signature of Mark		450. Signature of Luke	
451. Signature of John		452. Signature of Andrew		453. Signature of Thomas	
454. Signature of Philip		455. Signature of Bartholomew		456. Signature of Matthew	
457. Signature of James		458. Signature of John		459. Signature of Peter	
460. Signature of Paul		461. Signature of James		462. Signature of Matthew	
463. Signature of Mark		464. Signature of Luke		465. Signature of John	
466. Signature of Andrew		467. Signature of Thomas		468. Signature of Philip	
469. Signature of Bartholomew		470. Signature of Matthew		471. Signature of James	
472. Signature of John		473. Signature of Peter		474. Signature of Paul	
475. Signature of James		476. Signature of Matthew		477. Signature of Mark	
478. Signature of Luke		479. Signature of John		480. Signature of Andrew	
481. Signature of Thomas		482. Signature of Philip		483. Signature of Bartholomew	
484. Signature of Matthew		485. Signature of James		486. Signature of John	
487. Signature of Peter		488. Signature of Paul		489. Signature of James	
490. Signature of Matthew		491. Signature of Mark		492. Signature of Luke	
493. Signature of John		494. Signature of Andrew		495. Signature of Thomas	
496. Signature of Philip		497. Signature of Bartholomew		498. Signature of Matthew	
499. Signature of James		500. Signature of John		501. Signature of Peter	



TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

M

1

Items 18&2 Film 264 b-3-60 ams + b-6-60 ams									
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
05597									
Reg. Dist. No.									
5625									
1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>			c. LENGTH OF STAY IN lb <u>all his life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster, MD #4</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brehm Road</u>					d. STREET ADDRESS <u>Brehm Road</u>				
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>EDWARD</u> Middle <u>BREHM</u> Last					4. DATE OF DEATH <u>May</u> Month <u>26</u> Day <u>19</u> Year <u>60</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 20, 1890</u>		9. AGE (In years last birthday) <u>69</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Frederick Brehm</u>					14. MOTHER'S MARDEN NAME <u>Lottie Pickel</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>220-26-0731</u>		17. INFORMANT <u>Mrs. Chas. E. Brehm, Westminster, MD #4</u> Address <u>Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Frac. skull - Crushing injury to chest</u> <u>912.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Farm tractor upset on him</u>						
20c. TIME OF INJURY Month, Day, Year Hour <u>1</u> <u>May 26 60</u> <u>p. m.</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. (City or town) <u>Westminster</u> (County) <u>Carroll</u> (State) <u>Md</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>James T. Marsh</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/29/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Leister Cemetery</u>		22d. LOCATION (City, town, or county) <u>Rural Westminster, Md.</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>MAY 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kneale</u>		

INFORMATION ON THE DEATH OF A PERSON - (A) MORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**5626 CERTIFICATE OF DEATH**

05598

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived (if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Henryton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b <b>49 days</b>				d. STREET ADDRESS <b>653 W. Franklin Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Brownie</b> Middle <b>Cole</b> Last <b>Cole</b>				4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 2, 1902</b>	
9. AGE (In years lost birthday) <b>57</b> yrs		IF UNDER 1 YEAR Months <b>57</b> Days <b>27</b> Hours <b>19</b> Min <b>60</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Athen§ Georgia</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Harrison Cole</b>		14. MOTHER'S MAIDEN NAME <b>Ophelea Cole</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>259-10-4457</b>		17. INFORMANT <b>Brownie Cole - Patient</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>Profusely hemorrhage</b> DUE TO (c) <b>Far advanced bilateral cavitory pulmonary TB</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 8, 1960</b> to <b>May 27, 1960</b> , that (I) (we) last saw the deceased alive on <b>May 27, 1960</b> , and that death occurred at <b>5:45 P.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Edgars M. Maculans</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans, M.D.</b>	
22d. ADDRESS				22e. MED. PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION OR REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DATE <b>MAY 31 '60</b>							



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

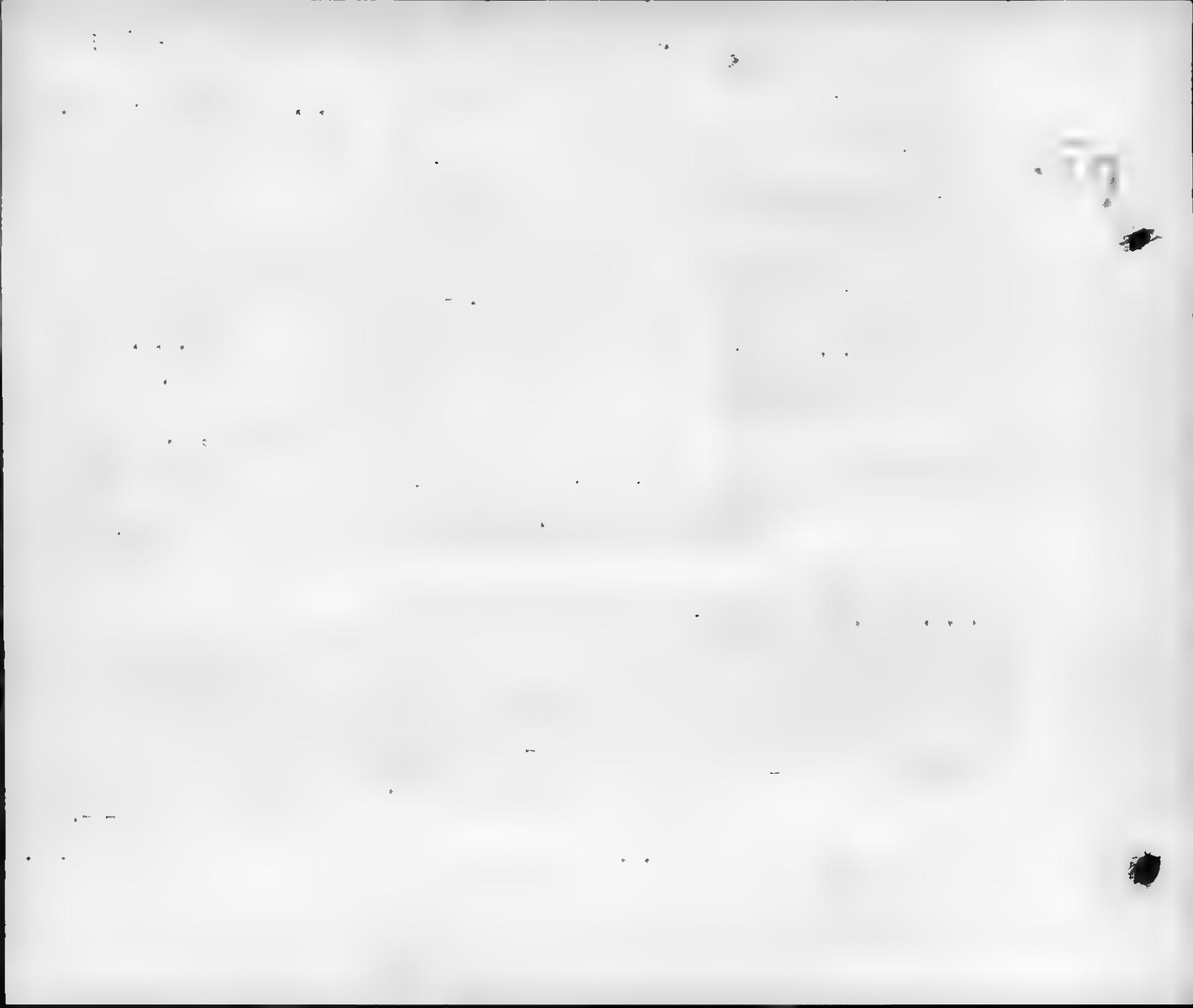
VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
5627 CERTIFICATE OF DEATH

05599

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Washington D.C.</b> COUNTY <b>Montgomery Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 16	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jesse</b> Middle <b>Edwin</b> Last <b>Coulter</b>		4. DATE OF DEATH Month <b>5</b> Day <b>8</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>/ Feb. 7 - 1879</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pennsylvania R.R. employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Coulter</b>		14. MOTHER'S MAIDEN NAME <b>Unknown LOVENIA BRYAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Hospital records Sykesville, Md.</b>	
17. INFORMANT <b>Hospital records Sykesville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>			
DUE TO <b>Generalized Arteriosclerosis</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
DUE TO (b) <b>Generalized Arteriosclerosis</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <b>C.B.S. assoc. with senile brain disease with psychotic reaction</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-22-1960</b> to <b>5-8-1960</b> , that (I) (we) last saw the deceased alive on <b>5-8-1960</b> , and that death occurred at <b>2:25 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo M.D.</b>		22b. DATE <b>5-8-1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo M.D.</b>		22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 11 - 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. Co. MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Kest</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 11 '60</b>	
ADDRESS <b>BOONSBORO MD</b>		25b. REGISTRAR'S SIGNATURE <b>Carl S. Kest</b>	





5628

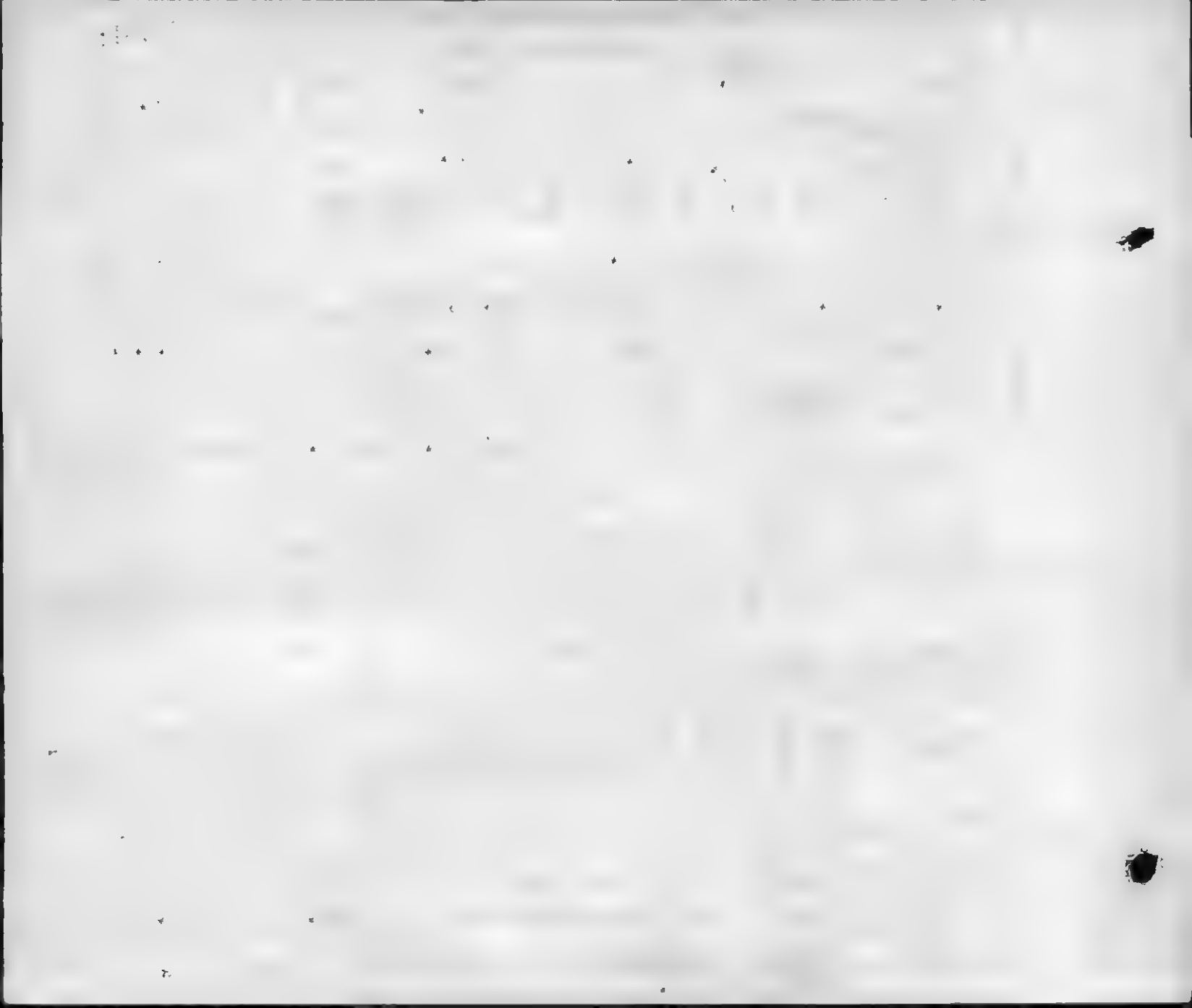
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eldersburg</b>				c. LENGTH OF STAY IN 1b <b>2Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Klee Mill Rest Home, Klee Mill Road</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b>			
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>L.</b> Last <b>Craig</b>				4. DATE OF DEATH Month <b>3</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 6, 1907</b>	9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Balto.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Tobias Abbott</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Frederick G. Craig Jr. 19 Bradbury Road</b> Address <b>Owings Mills, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>422</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>Coronary Arteriosclerosis</b> <b>Chronic Myocarditis</b> <b>Myocardial Regeneration</b>						INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>May 25, 1960</b> , to <b>May 26, 1960</b> , that I last saw the deceased alive on <b>May 25, 1960</b> , and that death occurred at <b>12:00 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Robert H. Gaston</b> M.D. <b>Lykesville Md.</b> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/30/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LORING BYERS</b> ADDRESS <b>8728 Liberty Road</b> <b>Randallstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 31 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05601
5629										CERTIFICATE OF DEATH
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>					c. LENGTH OF STAY IN 1b <b>21 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Valley Lee, Maryland</b> / X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Cutchember</b> Last					4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>19 60</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>? ? 1913</b>		9. AGE (In years last birthday) <b>47</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Valley Lee, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Deceased</b>					14. MOTHER'S MAIDEN NAME <b>Cora Cutchember</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>William Cutchember-Pt. Valley Lee, Md.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b>										
DUE TO (b) <b>Genito-Urinary tract infection following trauma</b>										
(c) <b>Pulmonary Tuberculosis Moderately Advanced</b>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>He gave a history of having fell with subsequent extravasation of urine into peni and scrotum</b>										
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>Mar 9 1960</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>about home</b>		20f. (City or town) <b>Valley Lee</b>		(County) <b>St. Marys</b> (State) <b>Md</b>	
21. I certify that I attended the deceased from <b>April 16</b> , 19 <b>60</b> , to <b>May 7</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>May 7</b> , 19 <b>60</b> , and that death occurred at <b>6:55 A.M.</b> , from the causes and on the date stated above.										
ACTUAL SIGNATURE <b>Edgars M. Maculans</b>					ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b>					
DATE SIGNED <b>5-7-60</b>										
PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans, Supt. Henryton State Hospital Henryton, Md.</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>5/9/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. George</b>		22d. LOCATION (City, town, or county) (State) <b>Valley Lee Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clark McHughley</b>					ADDRESS <b>Leonard town Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	





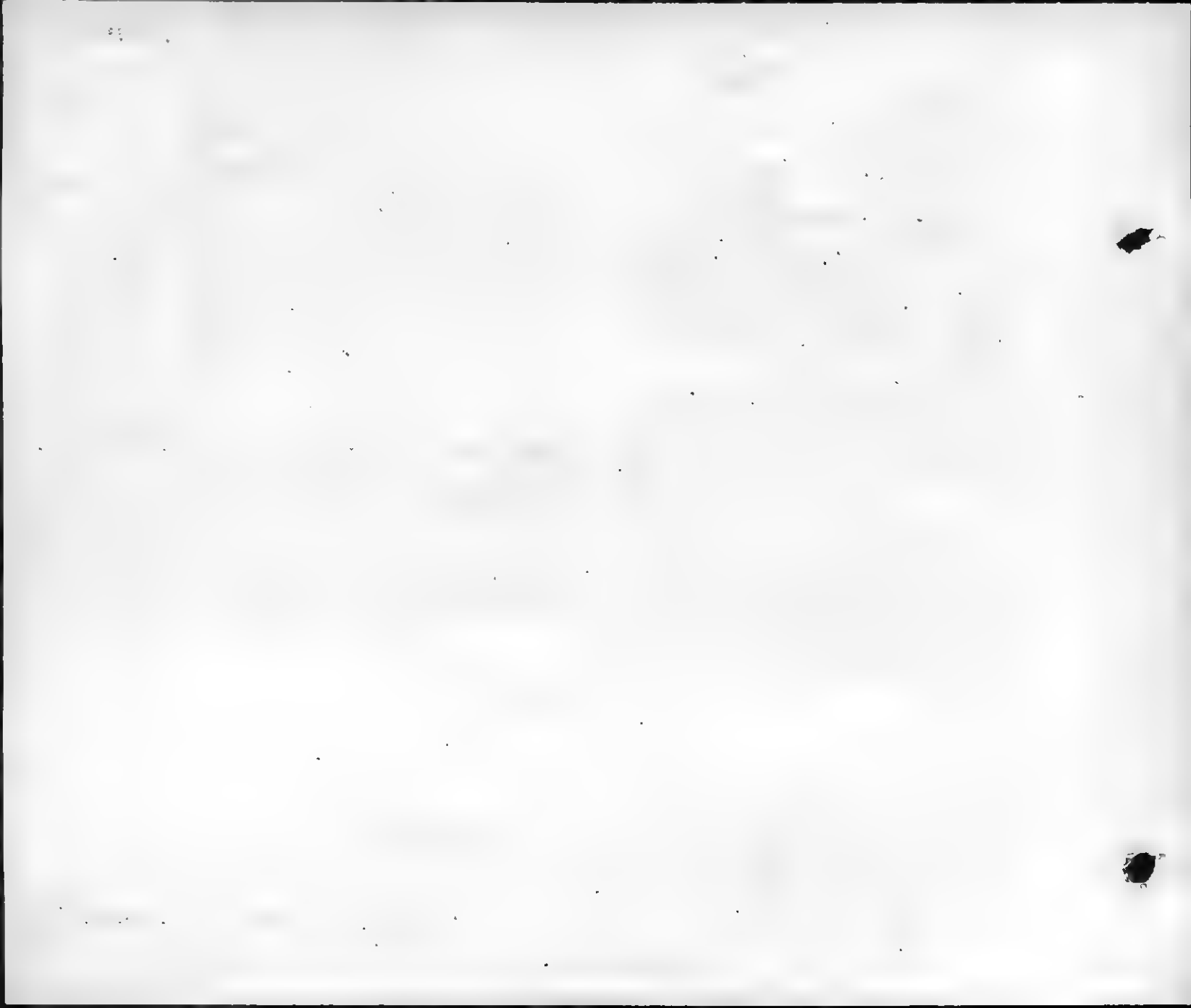
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cornell</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u> c. LENGTH OF STAY IN 1b <u>all her life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>22 Charles St.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cornell</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u> d. STREET ADDRESS <u>122 Charles St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ADA</u> First <u>BERTHA</u> Middle <u>DORSEY</u> Last		4. DATE OF DEATH Month <u>MAY</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>85</u> yrs.
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Westminster, Md. U.S.A.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Hill</u>		14. MOTHER'S MAIDEN NAME <u>Matilda?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>—</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exhaustion</u> DUE TO <u>Loss of Blood</u> DUE TO <u>Rectal Cancer</u> Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 week</u> <u>2 months</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>No injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>X</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>X</u>	20f. (City or town) (County) (State) <u>X</u> <u>X</u> <u>X</u>
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>49</u> , to <u>5-23</u> , 19 <u>60</u> that I last saw the deceased alive on <u>5-23</u> , 19 <u>60</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. Stone</u>		DATE SIGNED <u>5-23-60</u>	
PHYSICIAN'S NAME (Type) <u>W. E. Stone</u>		ADDRESS (Street, city or town, state) <u>121 E. Queen St. Westminster, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5/26/60</u>	<u>Ellsworth Cemetery</u>	<u>Rural Westminster, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers Jr.</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 26 '60</u>	
ADDRESS <u>Westminster, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



05603

Reg. Dist. No.

5631

## CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Md. RD #6</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Md. RD #6</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Near Chamber</u>		d. STREET ADDRESS <u>Near Chamber</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALVA FRIZZELL DORSEY</u>		4. DATE OF DEATH Month Day Year <u>May 29 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 2, 1901</u>
9. AGE (In years last birthday) <u>58</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Byard Dorsey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Frizzell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mrs. A. F. Dorsey Westminster, Md.</u>	
17. INFORMANT <u>Mrs. A. F. Dorsey Westminster, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Left Lung upper lobe &amp; extensive mediastinal &amp; anterior chest wall involvement</u> DUE TO (b) <u>Cerebral metastases</u> DUE TO (c) <u>Anemia &amp; Cachexia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1960</u> to <u>May 29, 1960</u> , that I last saw the deceased alive on <u>May 28, 1960</u> and that death occurred at <u>6:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Glenn Speicher M.D.</u>		DATE SIGNED <u>5/30/60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6/1/60</u>	<u>Westminster Cemetery Westminster, Md.</u>	<u>Westminster, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. M. M. Westminster, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 3 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

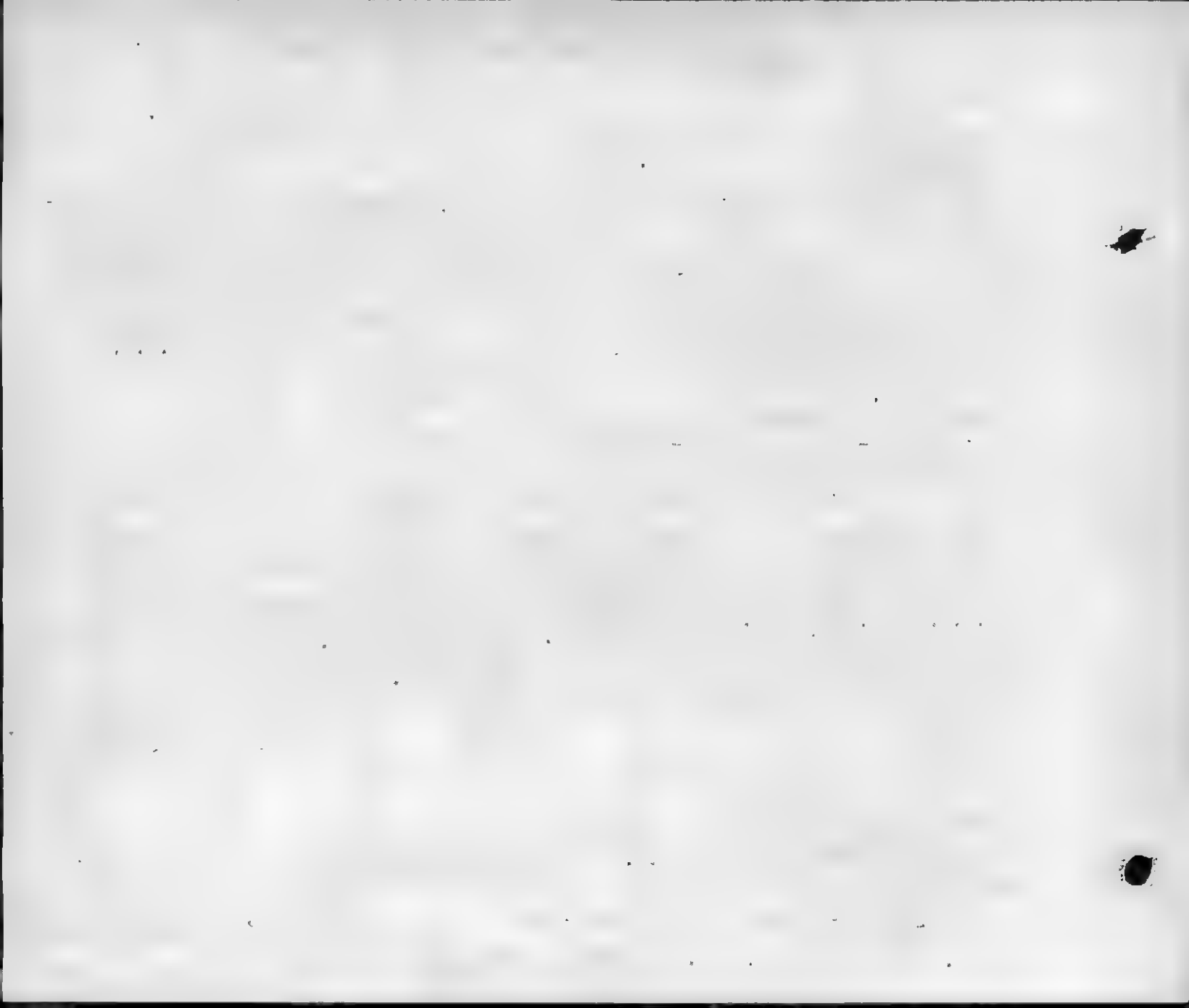
05604  
Reg. Dist. No.

5632

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>7mos. 3days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Calvin</b> Middle <b>Frankston</b> Last <b>Earp</b>		4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stationary engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas J. Earp</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Burke</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-12-7735</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute &amp; chronic ulcerative &amp; membranous colitis</b> DUE TO <b>colitis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease with psychotic reaction. Bronchopneumonia.</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Found lying on floor beside bed.</b>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour <b>4:00 AM</b> Min. <b>5/20/1960</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	
20f. (City or town) <b>Carroll County, Sykesville, Md.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>James T. Marsh, M.D.</b>		DATE SIGNED <b>May 25, 1960</b>	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-27-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons, Inc. 1900 Eutaw Place</b>		24a. REC'D BY REGISTRAR <b>MAY 31 1960</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Robert L. Marsh</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**5633** **CERTIFICATE OF DEATH**

05605

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton - Silver Spring</b>			
c. LENGTH OF STAY IN 1b <b>2y. 4mos. 27dy.</b>				d. STREET ADDRESS <b>12512 Bushey Drive</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Oliver</b> Middle <b>Franklin</b> Last <b>Fancey</b>				4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-11-91</b>		9. AGE (in years last birthday) <b>69</b> yrs	IF UNDER 1 YEAR: Months <b>23</b> Days <b>19</b> Hours <b>60</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Industry Consultant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Fancey</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Skelton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>106-03-4099</b>		17. INFORMANT <b>Springfield Hospital Records, Sykesville, Md.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Coronary arteriosclerosis</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>  <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome assoc. with cerebral arteriosclerosis-psychotic</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-26-57</b> to <b>5-23-</b> <b>19 60</b> , that (I) (we) last saw the deceased alive on <b>May 23</b> <b>1960</b> , and that death occurred at <b>4:50 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Agustin del Campo</i> M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>May 24, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo</b>				22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE THEREOF <b>5/26/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Utica, New York</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b> ADDRESS <b>2901 14th St. N.W. Washington, D.C.</b>				25a. REC'D BY REGISTRAR <b>MAY 25 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3/12

5634

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BROADWAY</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>SUSAN</u> Last <u>FOGLE</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 25-1891</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEVI WINTERS</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELLIOTT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HENRY T FOGLE</u> Address <u>UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interventricular Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/11/59</u> , 19 <u>  </u> , to <u>5/17/60</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>5/17/60</u> , 19 <u>  </u> , and that death occurred at <u>6:30 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. Caricoff</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1185 Main St., Union Bridge, Md. 5/17/60</u>			
PHYSICIAN'S NAME (Type) <u>JH CARICOFF</u>				<u>UNION BRIDGE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/20/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WINTERS</u>		22d. LOCATION (City, town, or county) (State) <u>NEW WINDSOR RURAL MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W D Hartzler &amp; Sons Union Bridge Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 20 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





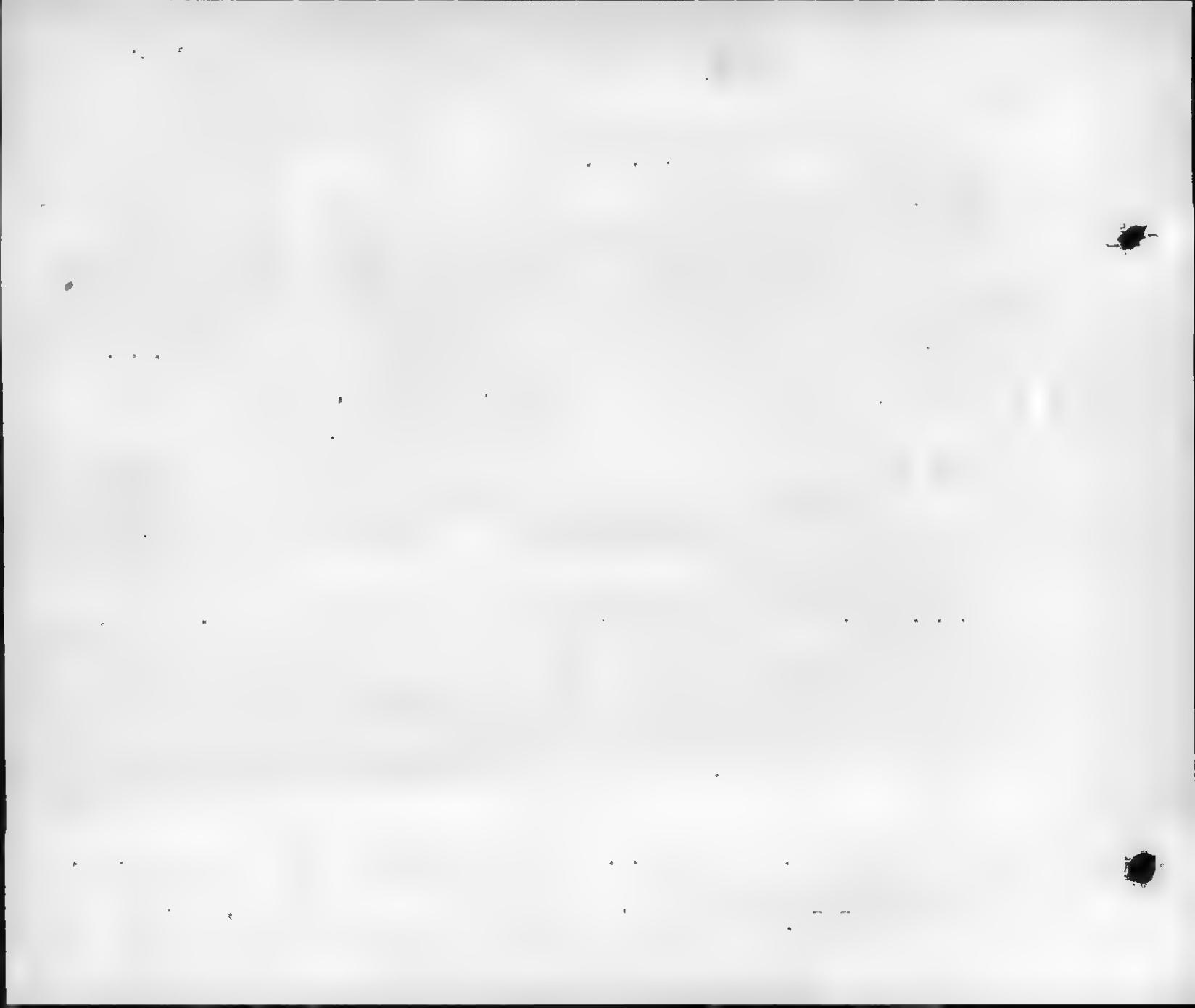
may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**5635** **CERTIFICATE OF DEATH**

05607

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2yrs. 1mo. 23days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>	
f. STREET ADDRESS <b>None</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rosa Ellen Albaugh Fogle</b>		4. DATE DEATH Month <b>May</b> Day <b>31</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1876</b>
9. AGE (In years lost birthday) <b>84</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Albaugh</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Albaugh (Valentine)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic heart disease</b> DUE TO (b) <b>Nephrosclerosis</b> DUE TO (c) <b>446X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 8, 1958</b> to <b>May 31, 1960</b> , that (I) (we) last saw the deceased alive on <b>May 30, 1960</b> , and that death occurred at <b>2:45 AM</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Ellis S. Margolin</b>		22b. DATE SIGNED <b>5/31/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ellis S. Margolin, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-2-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Bruger - Thurmont Md</b>		25a. REC'D BY REG STRAR DATE <b>JUN 3 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5636

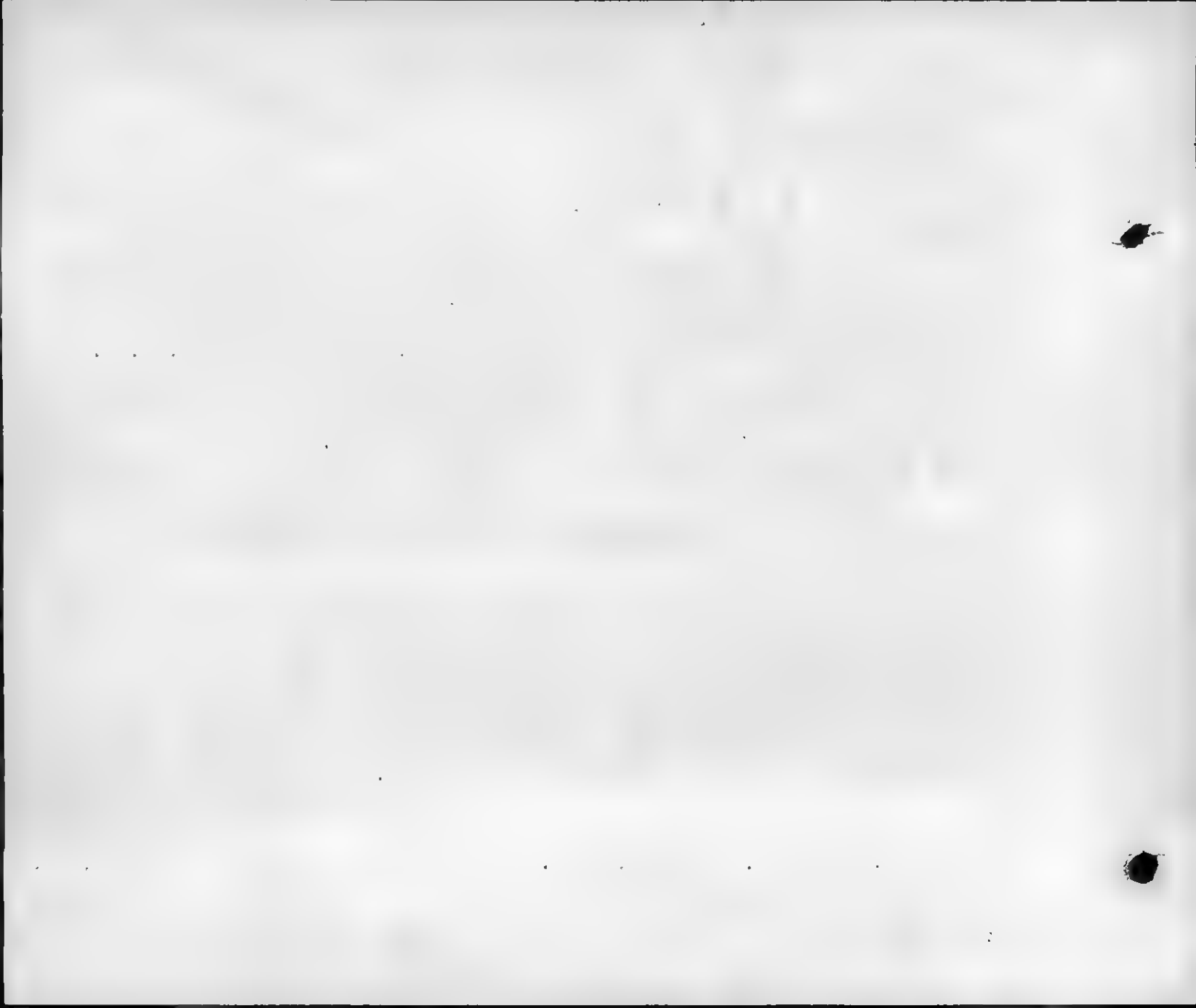
## CERTIFICATE OF DEATH

Reg. Dist. No.

05608

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Y</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton, Maryland</b>		c. LENGTH OF STAY IN lb <b>141 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Solomon</b> Middle <b>Fulcher</b> Last <b>Fulcher</b>		4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1890</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min. <b>69</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Augusta, Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Milton Fulcher</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Benjamine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Solomon Fulcher-Pt.</b>		Address <b>1202 Argyle Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Far advanced bilateral cavitory pulmonary TB</b> DUE TO (c) <b>.</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 16, 1959</b> , to <b>May 7, 1960</b> , that I last saw the deceased alive on <b>May 7, 1960</b> , and that death occurred at <b>12:20 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edgars M Maculans</b> M.D.		ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED <b>5-7-60</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.</b>			
22a. BURIAL CREMATION, -REMOVAL (Specify) <b>5-11-60</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Ignace</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>315 4 11 11</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE 5-8-60</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

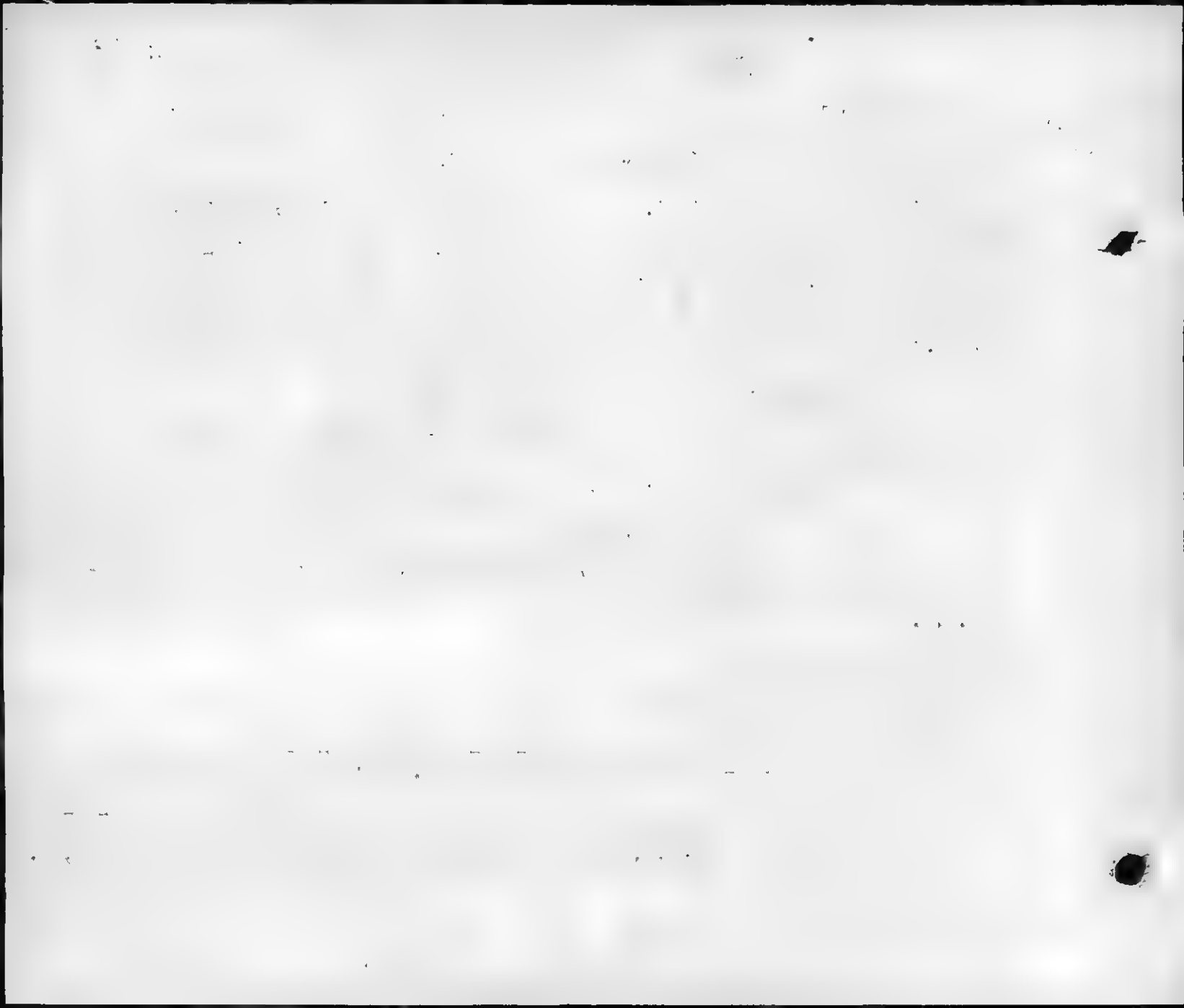


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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
5637 CERTIFICATE OF DEATH

05609

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore 28</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>6 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>		d. STREET ADDRESS <b>1006 Craftswood Road, Catonsville</b>	
3. NAME OF DECEASED (Type or print) <b>Elsie</b>		4. DATE OF DEATH Month <b>5</b> - Day <b>12</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1881</b>
9. AGE (In years last birthday) <b>79 ?</b> yrs		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Poland.</b>	
13. FATHER'S NAME <b>Piowarski</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Family</b>		Address <b>1006 Craftswood Catonsville 28</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Bronchopneumonia</b> DUE TO (b) <b>Chronic Heart Failure</b> DUE TO (c) <b>Hypertensive arteriosclerotic heart disease</b> C.B.S. due to cerebral arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>months</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. due to cerebral arteriosclerosis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5-12-1960</b> to <b>5-12-1960</b> , that (I) (we) last saw the deceased alive on <b>5-12-1960</b> , and that death occurred at <b>6:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Agustin del Campo</i>		22b. DATE <b>5-12-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>5/16/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>	23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Fred W. Ozazowski</i>		25a. REC'D BY REGISTRAR <b>May 16 '60</b>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film 5-83 5/18/60 iwk

## CERTIFICATE OF DEATH

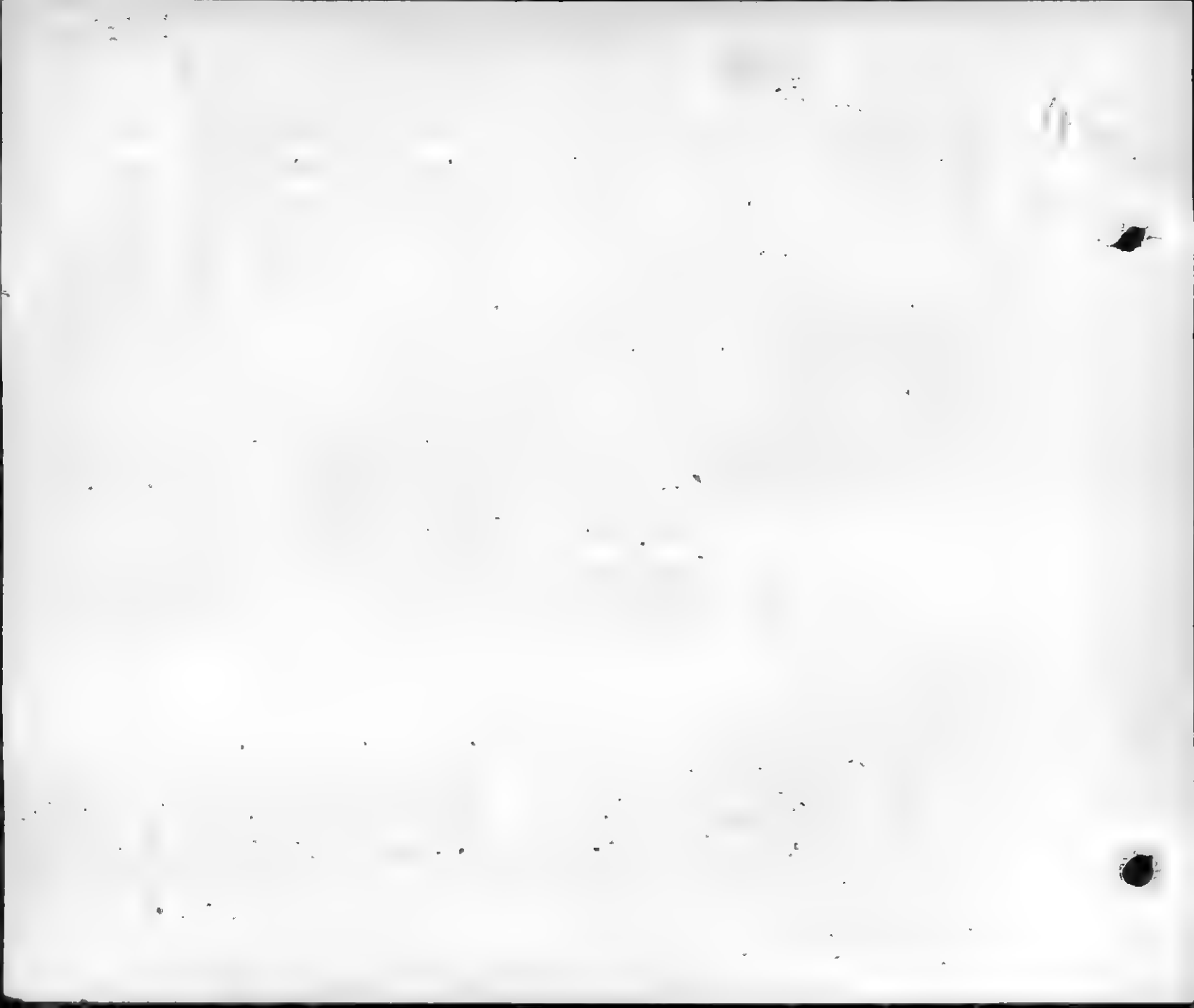
05610

Reg. Dist. No.

5618

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>				c. LENGTH OF STAY IN 1b <b>18 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Jordan Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>Sarah A. Haifley</b>				4. DATE OF DEATH Month <b>May</b> Day <b>4</b> Year <b>1960</b>			
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 19, 1872</b>	9. AGE (In years last birthday) <b>88 yrs.</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b> Hours <b>19</b> Min <b>60</b>	IF UNDER 24 HRS Months <b>4</b> Days <b>3</b> Hours <b>20</b> Min <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Masonhimer</b>				14. MOTHER'S MAIDEN NAME <b>Mary Duttera</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>D. Frank Haifley, Westminster, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 4723 DUE TO <b>Myocardial (Chr)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> (c) <b>Arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4-3-60</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <b>Apr</b> Day <b>19</b> Year <b>1950</b> Hour <b>5-3</b> a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>103 E Main Westminster Md</b>	
20f. (City or town) <b>Westminster</b>				20g. (County) <b>Carroll</b>		20h. (State) <b>Md</b>	
21. I certify that I attended the deceased from <b>Apr 1950</b> to <b>May 3-1960</b> , that I last saw the deceased alive on <b>5-3-1960</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wm C. Jennette</b> M.D.				DATE SIGNED <b>5-7-60</b>			
PHYSICIAN'S NAME (Type) <b>Wm C. Jennette MD</b>				ADDRESS (Street, city or town, state) <b>103 E Main Westminster Md</b>			
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 6, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baust Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Tyrone, Carroll, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Fuss &amp; Son</b>				ADDRESS <b>Taneytown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 9 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>							

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, with in 72 hours after death.

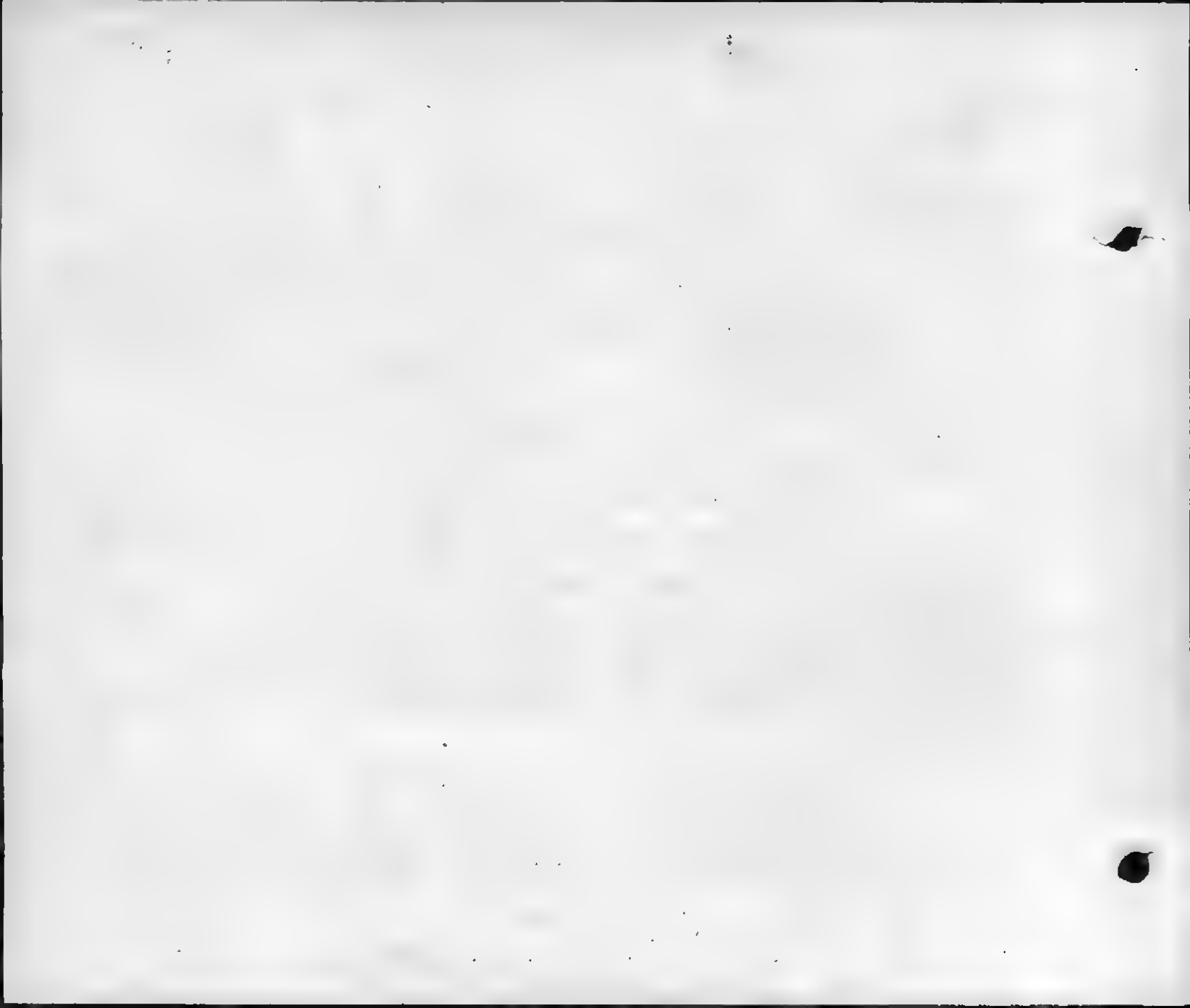
VR A15 (4)  
15M 9-59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
5638  
CERTIFICATE OF DEATH

05611

1 PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>				c. LENGTH OF STAY IN 1b <i>Cyr. 9mo</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <i>Clara B. Heil</i>				4. DATE OF DEATH <i>May 17 1960</i>			
5 SEX <i>F</i>	6 COLOR OR RACE <i>W.</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-24-83</i>	9 AGE (In years last birthday) <i>76</i> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <i>Texas</i>	12 CITIZEN OF WHAT COUNTRY? <i>By Birth</i>
13. FATHER'S NAME <i>Moses Baum</i>				14. MOTHER'S MAIDEN NAME <i>Betty Steiner</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>Springfield State Hosp. Records</i>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i>							<i>Days</i>
+20.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
(b) <i>Arteriosclerotic heart disease</i>							<i>Years</i>
DUE TO							
(c) <i>Coronary arteriosclerosis</i>							<i>Years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I							WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<i>Chronic bronchitis with pulmonary emphysema, asthma, and chronic w. psychotic reaction</i>							
19. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21 I certify that (1) (this hospital) attended the deceased from <i>8-18-1952</i> to <i>5-17-1960</i> that (1) (we) last saw the deceased alive on <i>5-17-1960</i> and that death occurred at <i>6:30 PM</i> from the causes and on the date stated above							
22a. SIGNATURE <i>Konstantin Weber</i>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Konstantin WEBER M.D.</i>				22d. ADDRESS <i>Oak St., Sykesville, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>5/19/60</i>		<i>Baltimore Cemetery</i>		<i>Baltimore Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i>				25a. REC'D BY REG STRAR		25b. REGISTRAR'S SIGNATURE	
<i>Ellsworth Armacost</i>				<i>MAY 20 '60</i>		<i>Arthur S. Kneass</i>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

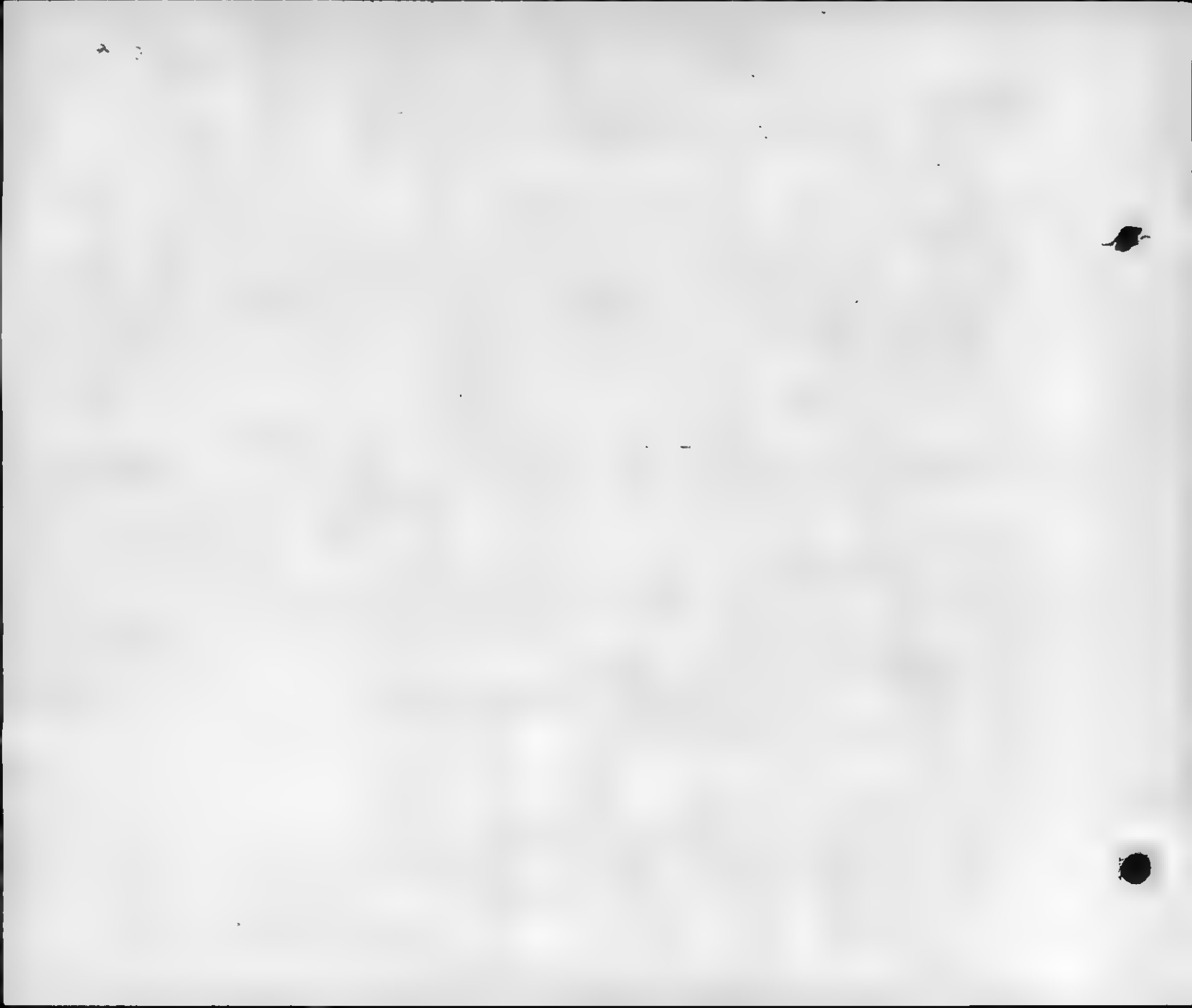
05612  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harney</u>		c. LENGTH OF STAY IN 1b <u>X</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route #2 Taneytown, (Harney)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 2 Taneytown</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Betty</u> Middle <u>May</u> Last <u>Hess</u>			4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>19 60</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 11, 1930</u>		9. AGE (In years last birthday) <u>29</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Mfr.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Robert G. McNeave</u>			14. MOTHER'S MAIDEN NAME <u>Adah L. Hahn</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u>		16. SOCIAL SECURITY NO. <u>220-26-0415</u>		17. INFORMANT <u>David W. Hess</u> Address <u>Taneytown, Md. R#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide Poisoning</u> <u>973.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Carbon monoxide poisoning from car fumes</u>			
20c. TIME OF INJURY Month, Day, Year <u>May 28 19 60</u> <u>1:50</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>car</u>	
20f. (City or town) <u>Taneytown</u>		20g. (County) <u>Carroll</u>		20h. (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>William J. Ford</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>May 29 1960</u>	
NAME (Type) <u>William J. Ford</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 1, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harney Lutheran Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Taneytown R.#2, Maryland</u>		22e. (State) <u>Md</u>		22f. (Country) <u>U.S.A.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Ford</u> <u>C.O. Fass &amp; Son</u>		ADDRESS <u>Taneytown, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 1 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hahn</u>					

MEDICAL CERTIFICATION

2

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the cause of the delay in the space provided. This certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



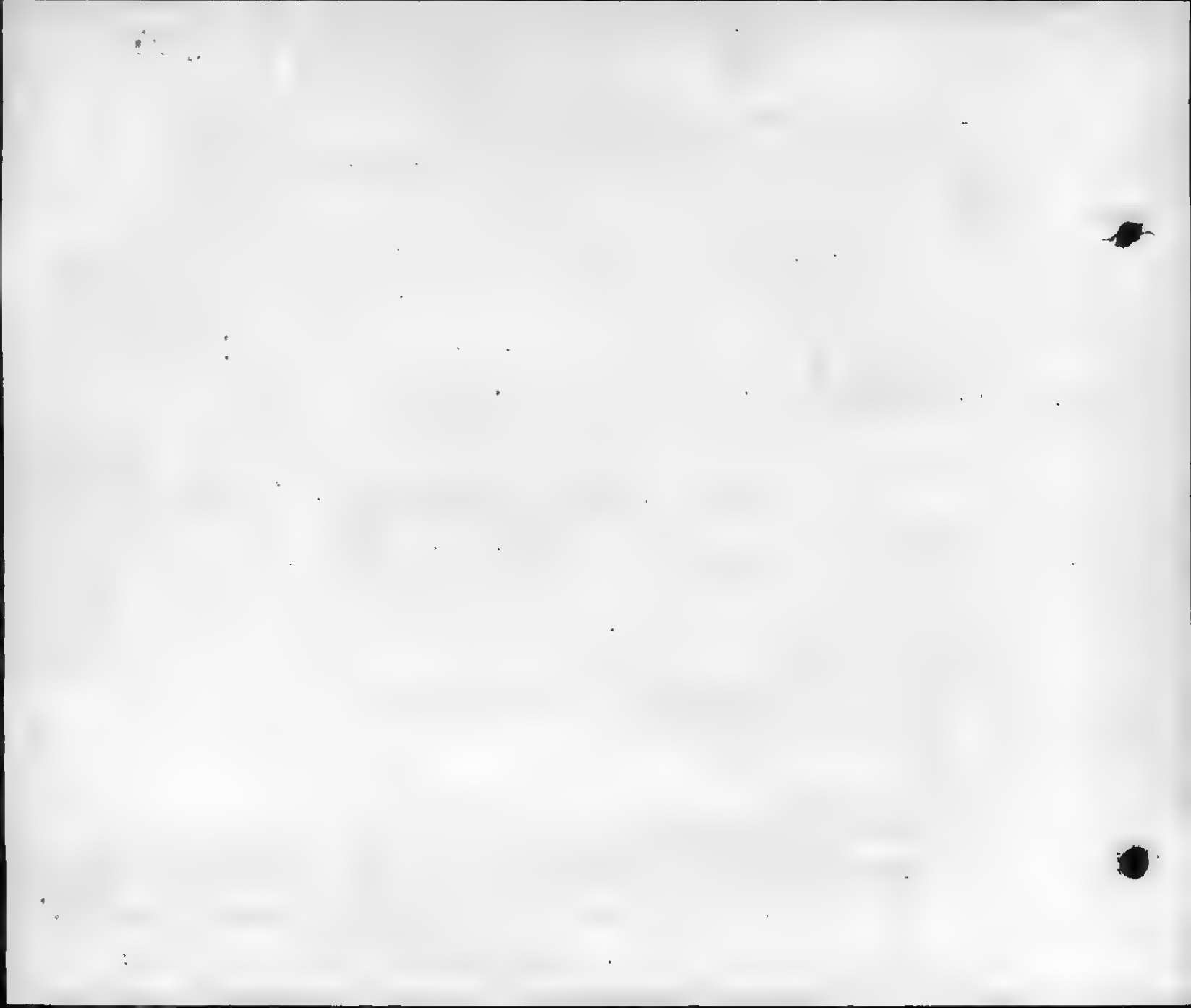
1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
5640  
CERTIFICATE OF DEATH

05613

1 PLACE OF DEATH a. COUNTY <u>CARROLL CO.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALESVILLE</u>				c. LENGTH OF STAY IN 1b <u>1 MO 9 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SAKIN FIELD STATE HOSP.</u>				d. STREET ADDRESS <u>410 E. MAIN ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First Middle Last <u>MARTHA FRANCES HOBBS</u>				4. DATE OF DEATH Month Day Year <u>MAY 21 1960</u>			
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/3/70</u>	9 AGE (In years lost birthday) <u>89</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Md. U.S.A. Frederick Co.</u>	12 CITIZEN OF WHAT COUNTRY? <u>JAME</u>
13 FATHER'S NAME <u>Ephraim ECKENRODE</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE ELIZABETH ELDER</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>None</u>		17 INFORMANT <u>J.S. HOSPITAL</u>		Address <u>SALESVILLE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO <u>CORONARY Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>acute ULCERATIVE MEMBRANOUS COLITIS</u> DUE TO <u>CAUSE UNKNOWN</u> (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u> <u>YEARS</u> <u>MO.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. ASSOC. WITH JENILE BRAIN DISEASE</u>							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>7/26</u> 19 <u>60</u> to <u>5/21</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>5/21</u> 19 <u>60</u> , and that death occurred at <u>1:2</u> M, from the causes and on the date stated above.							
22a SIGNATURE <u>Ellis Hargrave</u> M.D.				22b DATE SIGNED			
22c PHYSICIAN'S NAME (Type) <u>Frederick Co. Salesville Md.</u>				22d ADDRESS			
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>May 25, 1960</u>		23c NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Catholic</u>		23d LOCATION (City, town, or county) (State) <u>Emmitsburg, Frederick Co. Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Wilson (F&amp;W)</u>				ADDRESS <u>Emmitsburg Md.</u>		25a REC'D BY REG STRAR <u>MAY 24 '60</u>	
				25b REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>			

C. E. Wilson



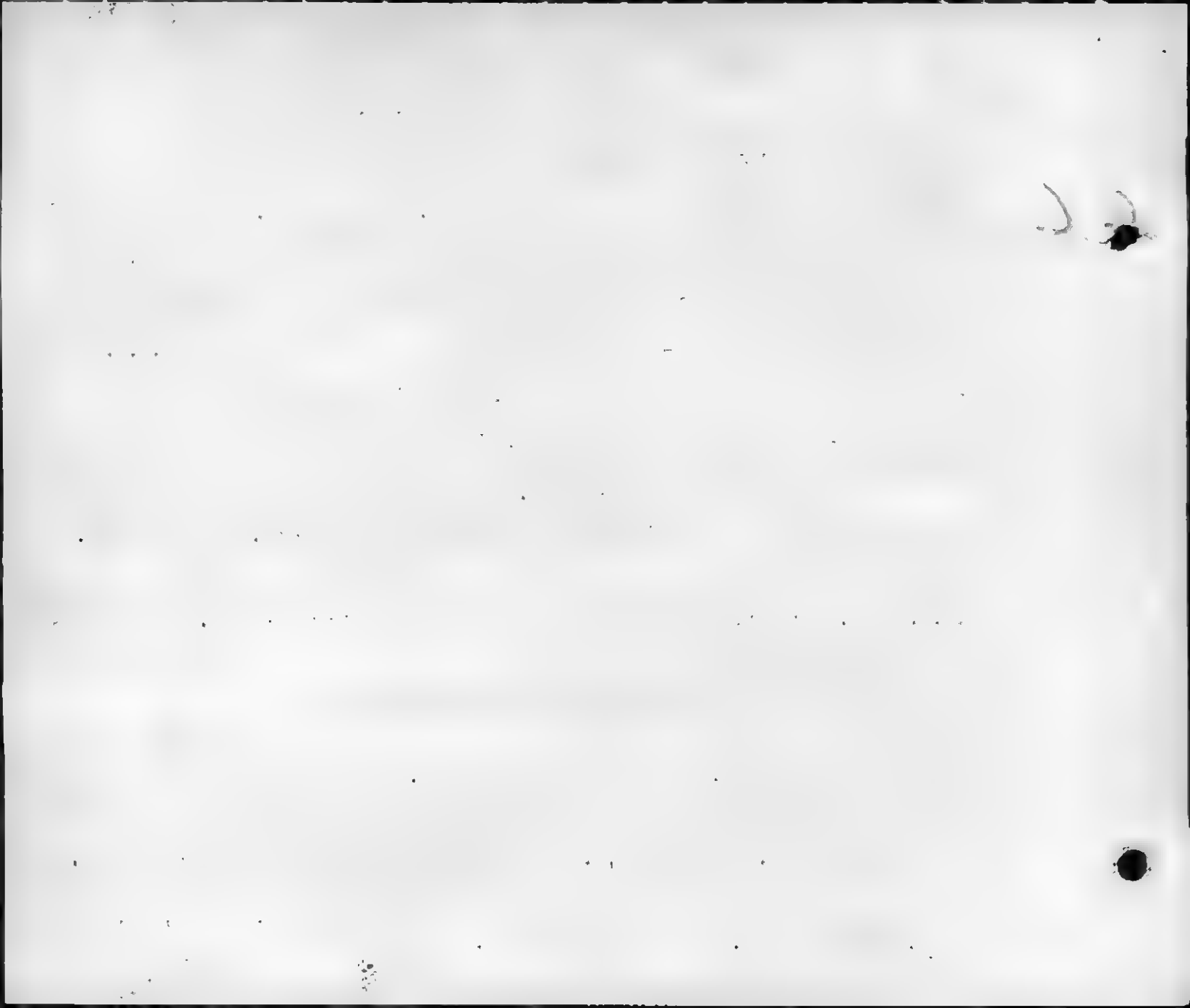
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
5641 CERTIFICATE OF DEATH

05614

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>22 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. STREET ADDRESS <b>200 E. Franklin Ave.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edith Elizabeth Wakelin Hodges</b>				4. DATE OF DEATH Month Day Year <b>May 31, 1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 18, 1867</b>	9. AGE (In years last birthday) <b>92</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>England</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>- Wakelin</b>				14. MOTHER'S MAIDEN NAME <b>Mary Louise Kynaston</b> ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Arteriosclerotic cardiovascular disease.</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>  <b>Years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>May 2, 1960</b> , to <b>May 31, 1960</b> , that (I) (we) last saw the deceased alive on <b>May 30, 1960</b> , and that death occurred at <b>5:05AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Heinz H. Klaatsch</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE <b>5/31/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Heinz H. Klaatsch, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/3/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska</i>				ADDRESS <b>SILVER SPRING, MD.</b>		25a. REC'D BY REGISTRAR <b>JUN 6 '60</b>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			





5619

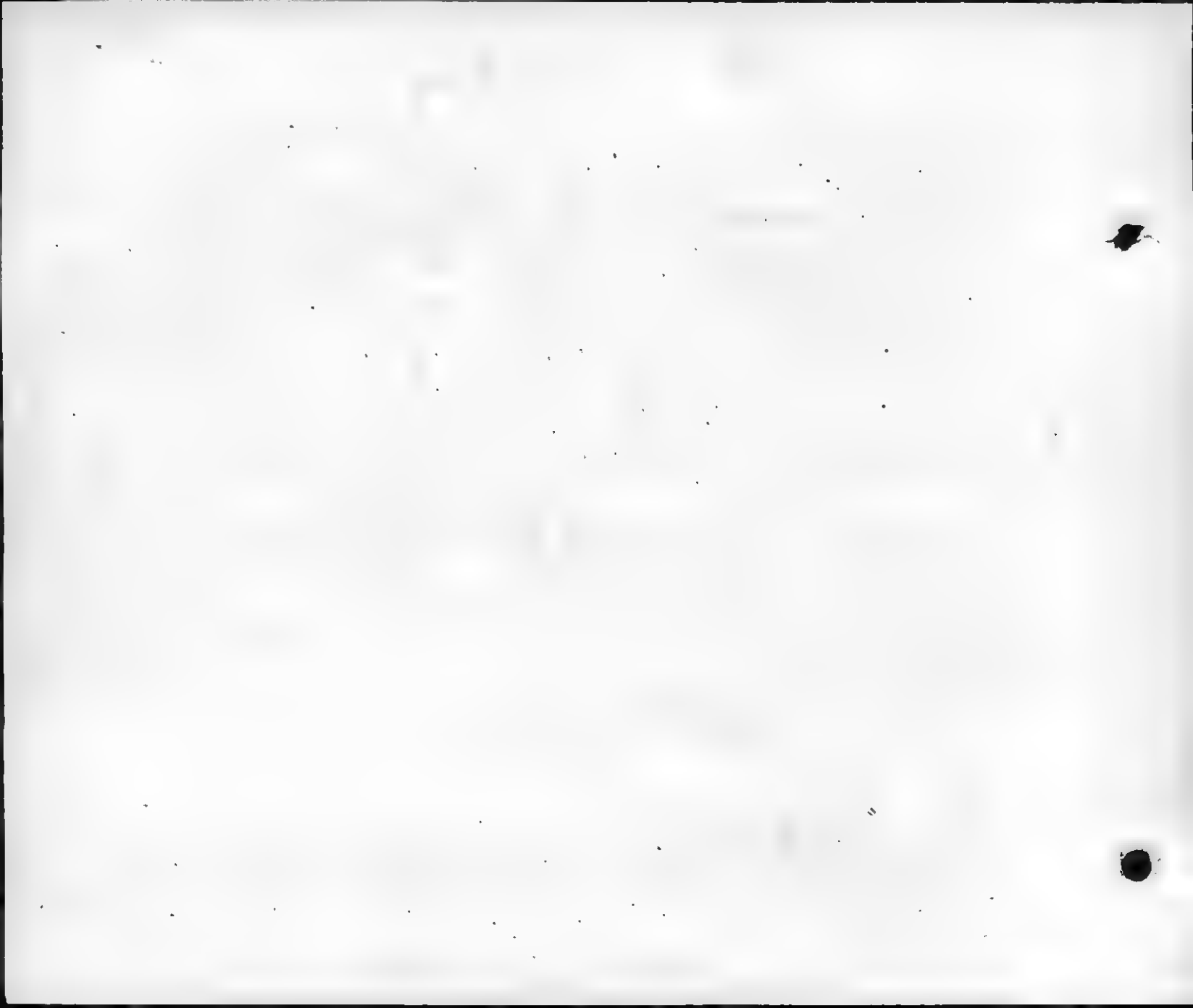
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
c. LENGTH OF STAY IN 1b <u>2 2 yrs</u>				d. STREET ADDRESS <u>152 Lincoln Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>152 Lincoln Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ELIZABETH U. HOOPER</u>				4. DATE OF DEATH <u>May 21 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 19, 1906</u>	
9. AGE (In years last birthday) <u>53</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School-Carroll County Schools</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Palmer W. Brightford</u>				14. MOTHER'S MAIDEN NAME <u>Hattie North</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO <u>212-387647</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocarditis (Chr)</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Hypertension</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>54</u> <u>54</u>			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 1954</u> to <u>May 21 - 60</u> , that I last saw the deceased alive on <u>May 20 - 60</u> , and that death occurred at <u>4:05 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm C. Jennette</u> M.D.				DATE SIGNED <u>5-21-60</u>			
PHYSICIAN'S NAME (Type) <u>Wm C. Jennette M.D.</u>				<u>Westminster Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/23/60</u>		<u>Westminster Cemetery</u>		<u>Westminster Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Meyer, Jr.</u>				24a. REC'D BY REGISTRAR <u>DATE MAY 24 '60</u>			
ADDRESS <u>Westminster, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Caroline S. Hanna</u>			

TO REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be signed by the funeral director, by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

1

3642

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5642

CERTIFICATE OF DEATH

05616

Ca rroll

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Agnes Virginia Hoppe</b>				4. DATE OF DEATH Month Day Year <b>May 15 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-17-71</b>	
9. AGE (In years last birthday) <b>89 yrs</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Music Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Ridgely Morgan</b>				14. MOTHER'S MAIDEN NAME <b>Harriet Welch</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>410.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Acute Pyelo Nephritis</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C. B. S. associated with Circulatory Disturbance, cerebral Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>weeks</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-4</b> 1960, to <b>5-15</b> 1960, that (I) (we) last saw the deceased alive on <b>5-15</b> 1960, and that death occurred at <b>11AM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Agustin del Campo</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo</b>	
22d. ADDRESS <b>Springfield State Hosp, Sykesville, Md.</b>				22e. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22f. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-17-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Burke</b>				24a. ADDRESS <b>1756 Pa. Ave., N.W.</b>		24b. REC'D BY REGISTRAR <b>DATE MAY 18 '60</b>	
24c. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>				24d. DATE			

MEDICAL CERTIFICATION



may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

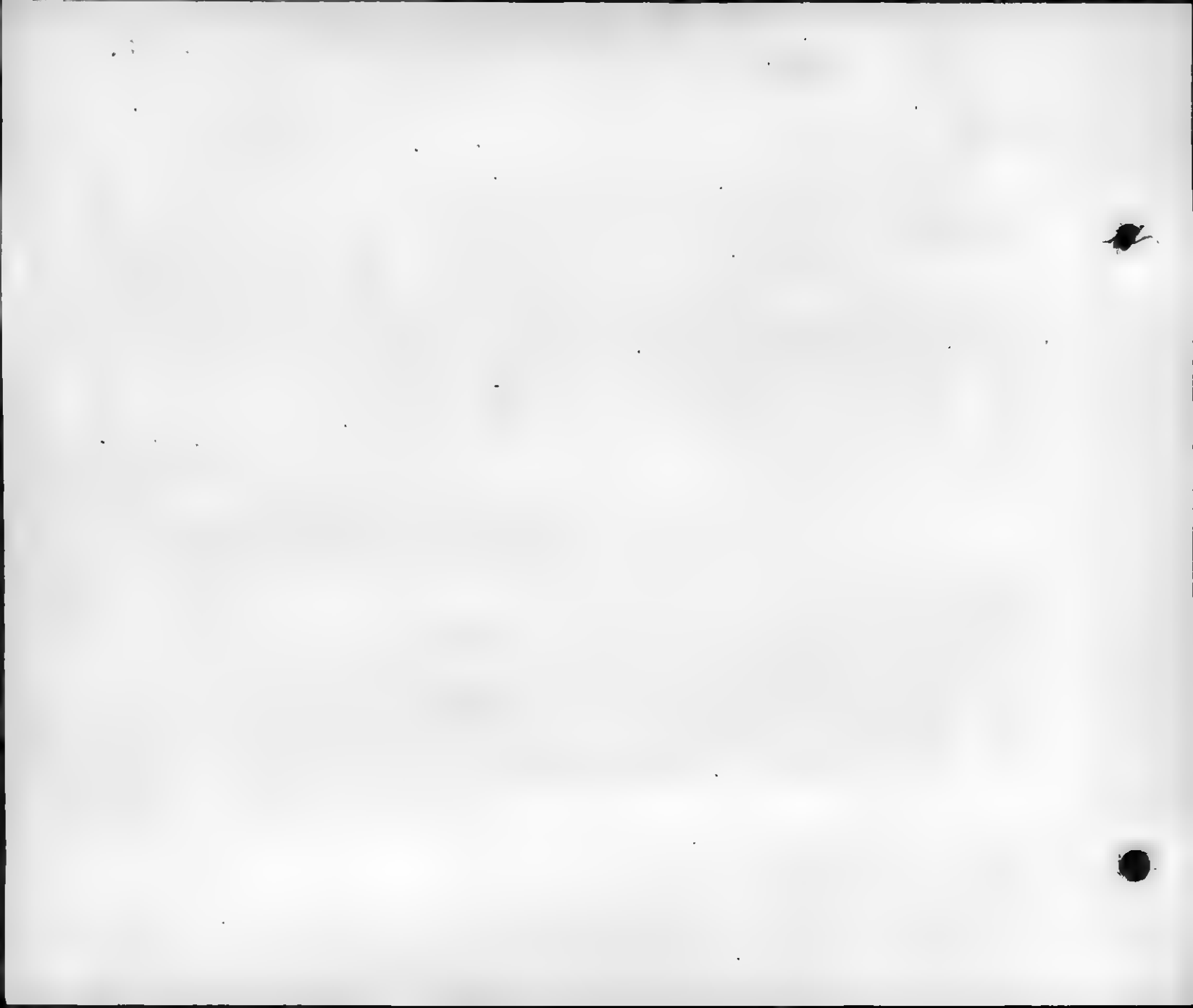
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5643

Item 1 **CERTIFICATE OF DEATH**

05617

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>144 Center Ave. home</u> (Son's)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Harford</u>	
3. NAME OF DECEASED (Type or print) <u>NELLIE BECK HORMAN</u> First Middle Last		4. DATE OF DEATH <u>MAY 28 1960</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1883</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	9c. AGE (In years last birthday) <u>76</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	10c. BIRTHPLACE (State or foreign country) <u>MD</u>
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Harmon</u>		14. MOTHER'S MAIDEN NAME <u>Mary Snyder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>10-1000000000</u>	
17. INFORMANT <u>Mrs. E. Harmon</u> Address <u>144 Center Ave., Harford, Md.</u>		18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>generalized arteriosclerotic heart disease</u> DUE TO (c) <u>anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1958</u> <u>TO</u> <u>28 May 60</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1958</u> to <u>28 May 1960</u> that (I) (we) last saw the deceased alive on <u>27 May 1958</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Howard E. Hall</u> M.D.		22b. DATE SIGNED <u>28 May 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		22d. ADDRESS <u>SYKESVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>5-31-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew's</u>	23d. LOCATION (City, town, or county) (State) <u>Carlisle, Harford, MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hanna</u> ADDRESS <u>144 Center Ave., Harford, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 1 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

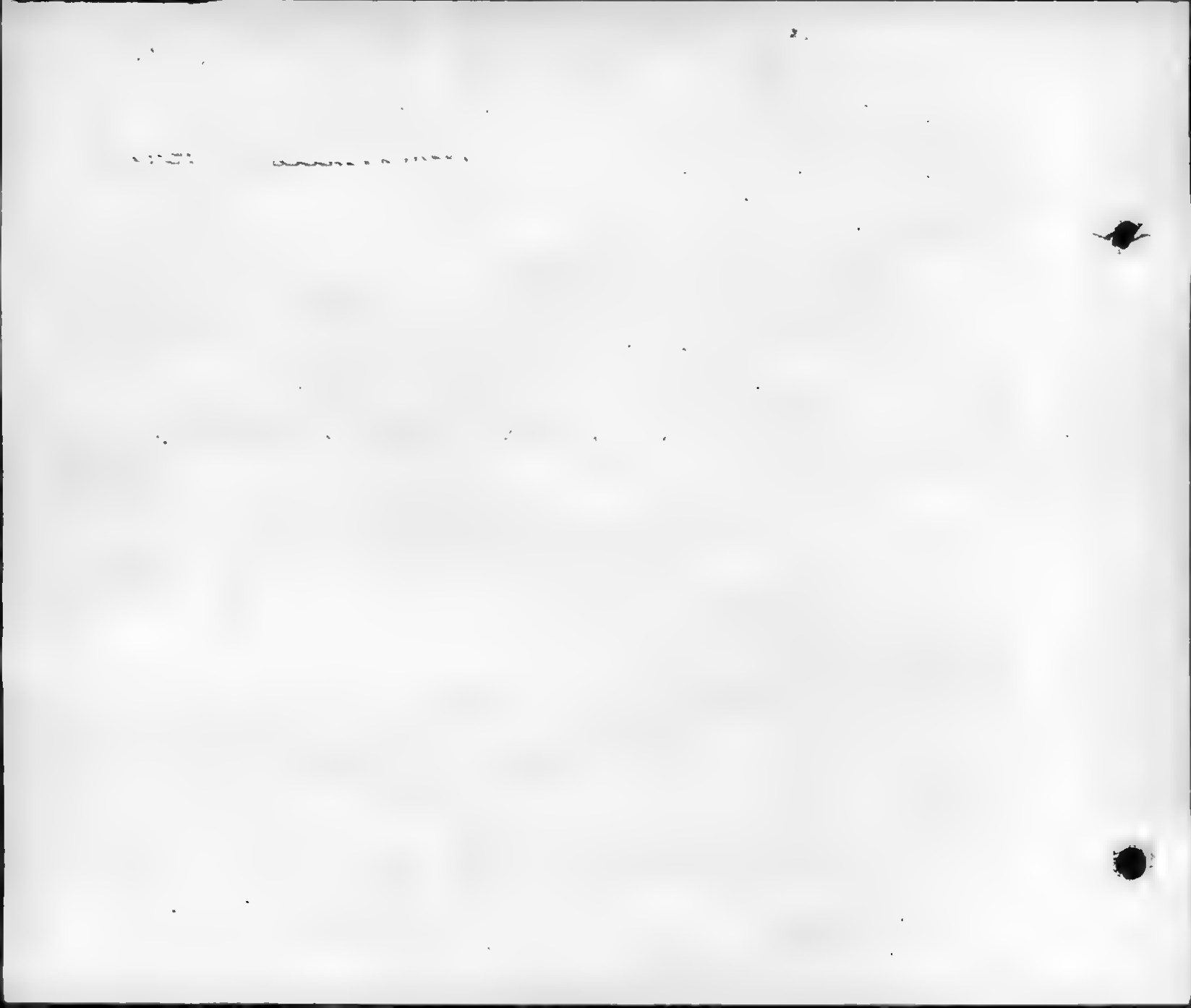


may be returned by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 5644  
 CERTIFICATE OF DEATH

05618

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville Road 1 Wk</u>				c. LENGTH OF STAY IN 1b <u>X Sykesville Rural</u>			
d. NAME OF HOSPITAL (If not in hosp. tol. give street address) OR INSTITUTION <u>Solden Agr. Conv. Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Jela - First G. Kelbaugh</u>				4. DATE OF DEATH <u>May 4 1960</u>			
5 SEX <u>M</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>July 11-1878</u>	
10a USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W Kelbaugh</u>				14 MOTHER'S MAIDEN NAME <u>Laura Munay.</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>no</u>		17 INFORMANT <u>J W Kelbaugh - Hampstead Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Embolism</u> DUE TO <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sub intussusception</u> DUE TO <u>15 yr</u> (c) <u>hypertension</u> <u>Long</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio Sclerosis back</u>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21 I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a SIGNATURE <u>MORRELL N MASTIN</u>				22b. DATE SIGNED <u>May 4 1960</u>			
22c PHYSICIAN'S NAME (Type) <u>MORRELL N MASTIN</u>				22d ADDRESS <u>Sykesville Md</u>			
23a BURIAL, CREMATION, or DISPOSAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 7/60</u>		<u>Hampstead</u>		<u>Carroll Co Md</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Edw. S. Supton</u>				ADDRESS <u>Hampstead Md</u>		25a REC'D BY REGISTRAR DATE <u>MAY 10 '60</u>	
						25b REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	





may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corpse papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

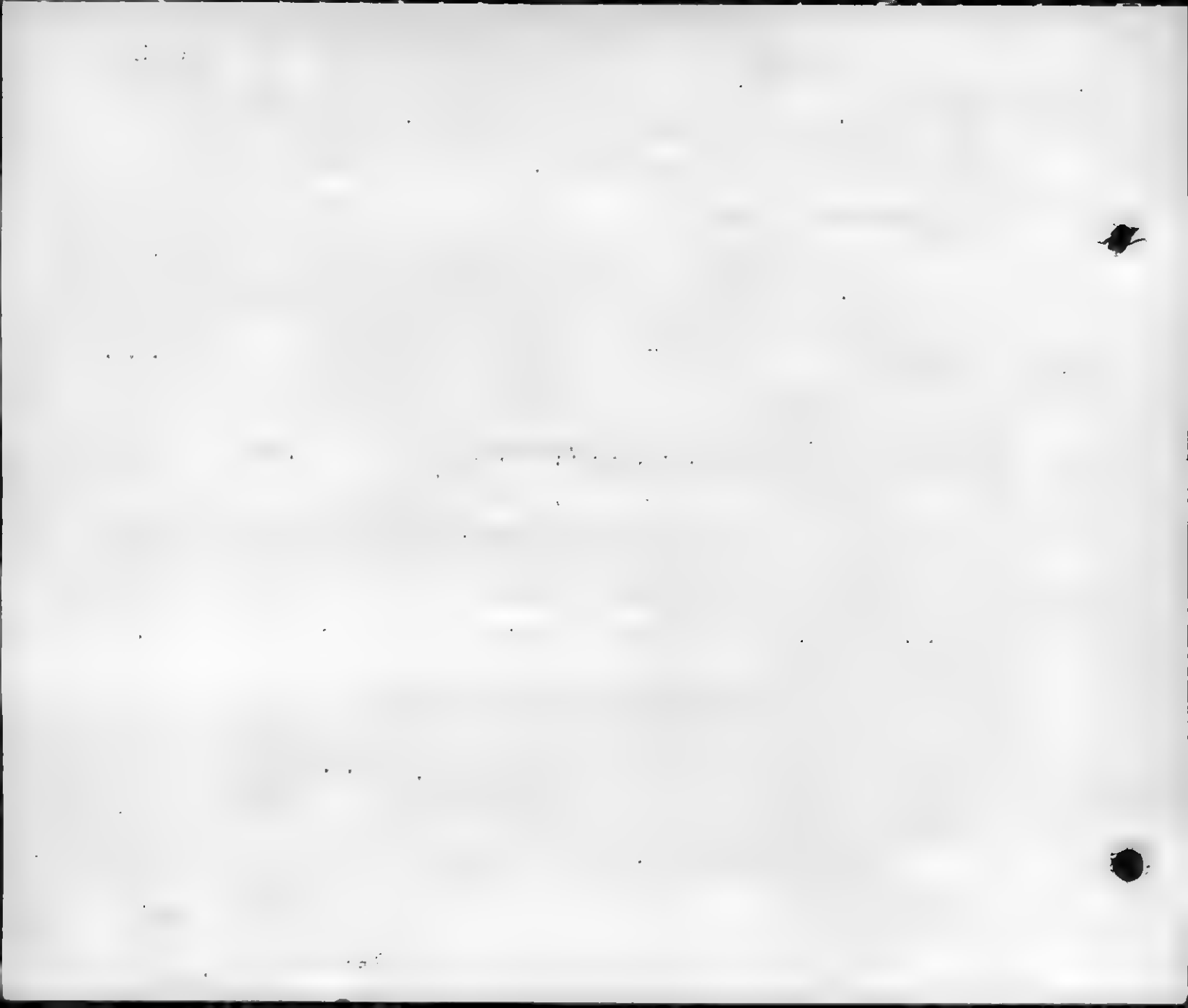
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5645

## CERTIFICATE OF DEATH

05619

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>3 mos. 13 dys.</b>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. STREET ADDRESS ---			
3 NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>William</b> Last <b>LaRue</b>				4 DATE OF DEATH Month <b>5</b> Day <b>10</b> Year <b>19 60</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>9-22-67</b>		9. AGE (In years last birthday) <b>92</b> yrs	IF UNDER 1 YEAR Months <b>10</b> Days <b>19</b> Hours <b>60</b>	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY ---		11 BIRTHPLACE (State or foreign country) <b>Maryland Finzel</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac LaRue</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Durst</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16 SOCIAL SECURITY NO. ---		17 INFORMANT Address <b>Springfield Hospital Records Sykesville</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>							<b>years</b>
DUE TO (b) <b>Coronary arteriosclerosis</b>							<b>years</b>
DUE TO (c) <b>Abscess in left lung</b>							<b>months</b>
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with cerebral arteriosclerosis, with psychotic reac.</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>January 27, 1960</b> to <b>May 10, 1960</b> that (I) (we) last saw the deceased alive on <b>May 10, 1960</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <i>Agustin del Campo</i>				22b. DATE <b>5-11-60</b>		22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo M.D.</b>	
22d. ADDRESS <b>Springfield State Hospital, Sykesville, MD.</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. DATE <b>5-11-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>May 19, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Johnson Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Near Frostburg, Garrett Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Hafer</i>				25a. RECEIVED BY REGISTRAR <b>DATE MAY 24 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

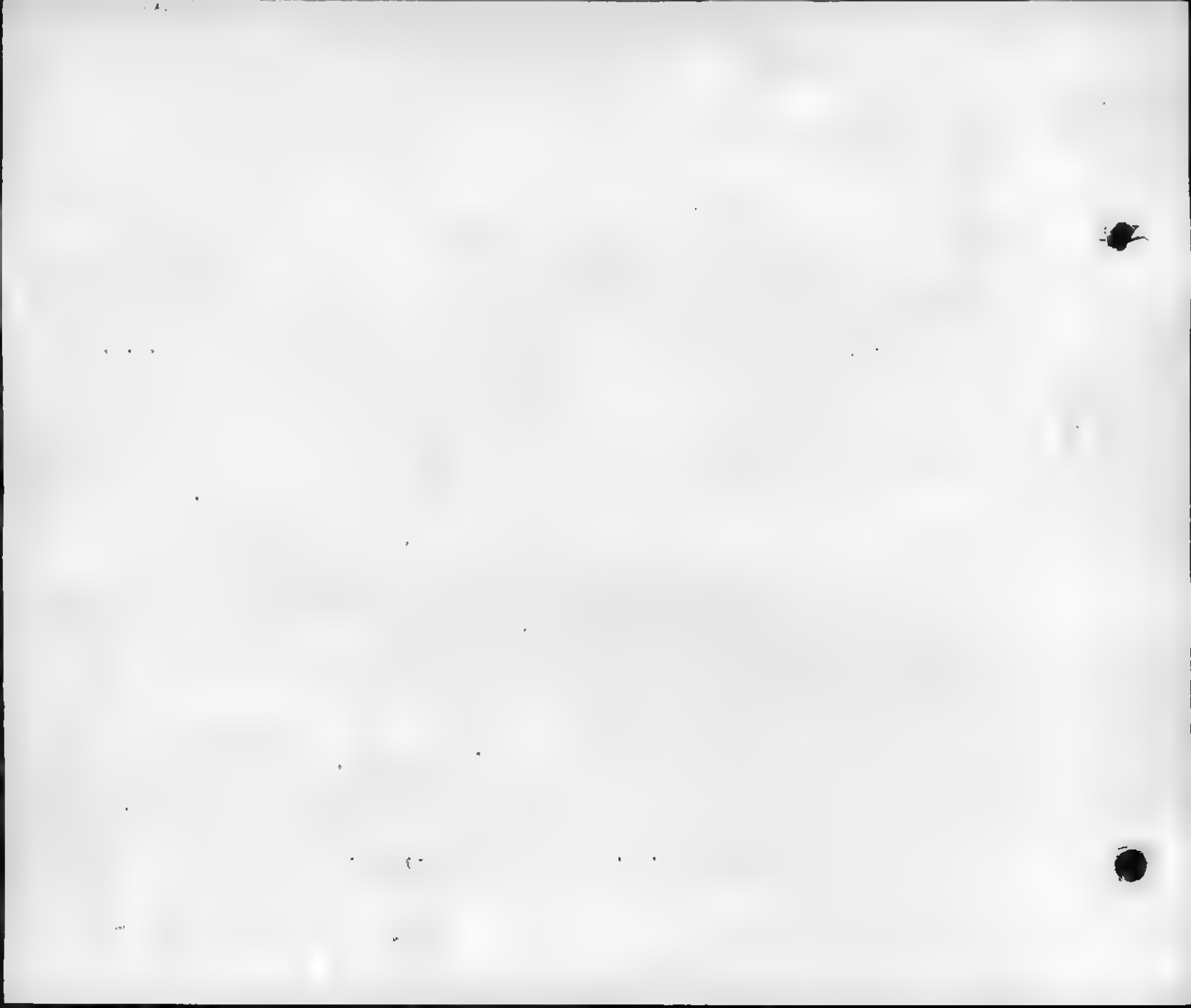


may be returned by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, and in any event, within 72 hours after death.

5645

05620

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institut n Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>25 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Margaret</b>		4. DATE OF DEATH Month <b>5</b> Day <b>19</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/29/99</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mill worker</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>	9c. BIRTHPLACE (State or foreign country) <b>Pennsylvania Pittsburgh U.S.A.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mill worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania Pittsburgh U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Fullerton</b>		14. MOTHER'S MAIDEN NAME <b>Margaret McLean</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>?</b>	
17. INFORMANT <b>Springfield State Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic carcinoma in lungs, skull and ribs.</b> DUE TO (b) <b>Primary site not discovered.</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic Reaction, Paranoid Type.</b>			
19. WAS ALTPROF PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 8, 1934</b> to <b>May 19, 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 19, 1960</b> , and that death occurred at <b>4:35 p.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Konstantin Weber</b>		22b. DATE SIGNED <b>5/20/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Konstantin Weber, M. D.</b>		22d. ADDRESS <b>Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-23-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		25a. REC'D BY REGISTRAR <b>MAY 24 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/59

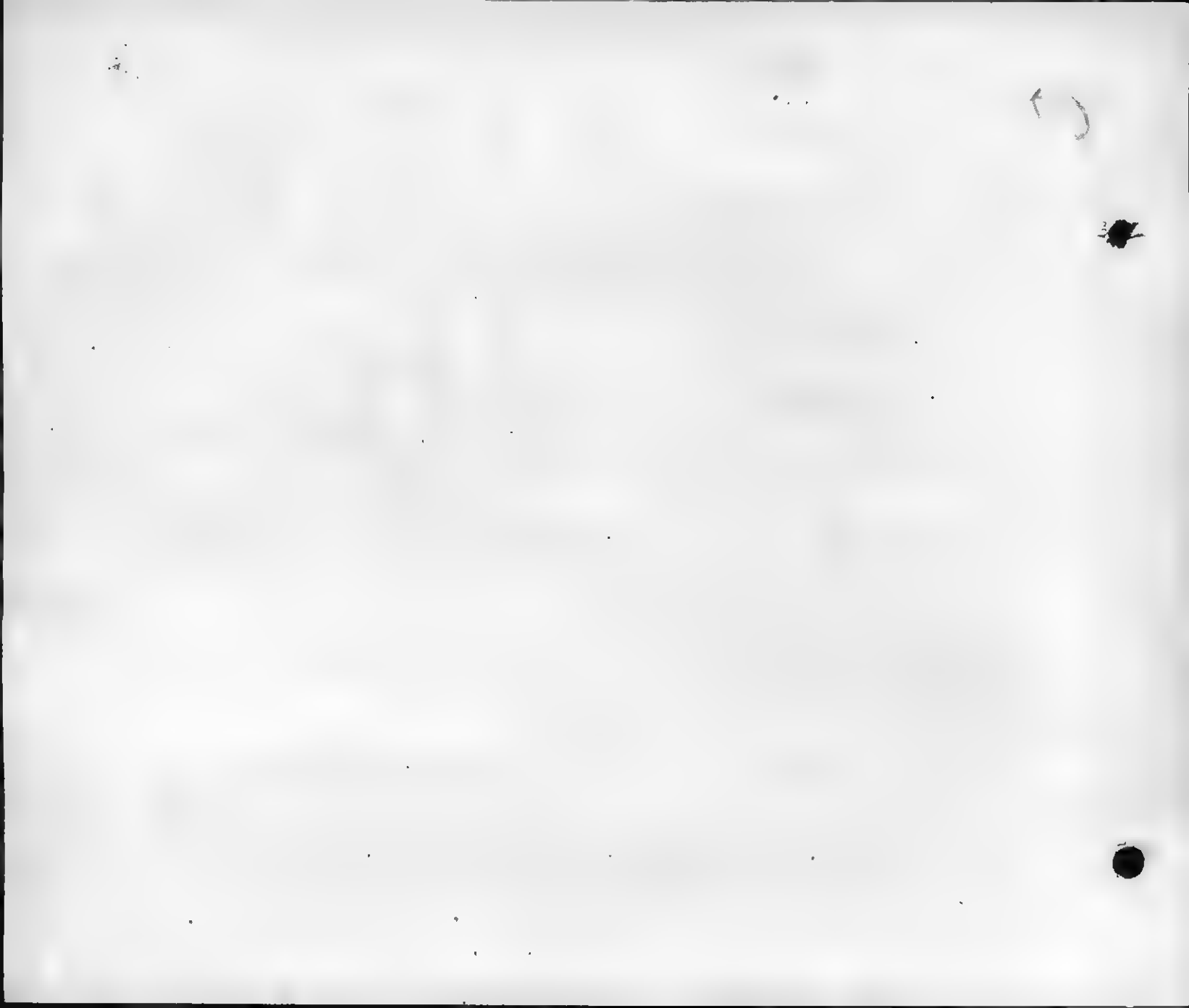
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5647

CERTIFICATE OF DEATH

05621

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b> c. LENGTH OF STAY IN 1b <b>20 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b> d. STREET ADDRESS <b>27001 Ridge Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Harrison</b> Last <b>Lyles</b>		4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>1960</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1-13-1891</b>
9. AGE (In years lost birthday) <b>69</b> yrs		10. IF UNDER 1 YEAR Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min <b>69</b>	11. IF UNDER 24 HRS Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min <b>69</b>
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Damascus, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jefferson Lyles</b>		14. MOTHER'S MAIDEN NAME <b>Isabel Steen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown, If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>214-12-7656</b>	
17. INFORMANT <b>William H. Lyles-Pt.</b>		Address <b>27001 Ridge Road</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Coronary Thrombosis</b> DUE TO (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Far Advanced Bilateral Pulmonary Tuberculosis</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 9</b> 19 <b>60</b> to <b>May 30</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>May 30</b> 19 <b>60</b> , and that death occurred at <b>3:30 A.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Edgars M. Maculans</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type or print) <b>Edgars M. Maculans, Supt.</b>		22d. ADDRESS <b>Henryton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 1, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Friendship Meth.</b>		23d. LOCATION (City, town, or county) (State) <b>Damascus, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. Moleworth</b>		25a. REC'D BY REGISTRAR <b>Damascus, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>DATE JUN 1 '60</b>		25c. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5648

05622

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>2 mos. 16 dys.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 18, Md.</b> d. STREET ADDRESS <b>2746 Alameda</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bertha Gertrude McCracken</b>		4. DATE OF DEATH Month Day Year <b>May 17 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-4-94 1887</b>
9. AGE (In years last birthday) <b>66 73</b>		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Whitten</b>		14. MOTHER'S MAIDEN NAME <b>Mary Evans</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Springfield Hospital Records</b>		Address <b>Sykesville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>			
420.0 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <b>Arteriosclerotic Heart Disease</b>			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Latent Syphilis</b>			
<b>Chronic Brain Syndrome assoc. with Arteriosclerotic heart disease.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 1 1960</b> , to <b>May 17 1960</b> , that (I) (we) last saw the deceased alive on <b>May 17, 1960</b> , and that death occurred at <b>11:40 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Agustin del Campo</i> M.D.		22b. DATE SIGNED <b>May 17, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo M.D.</b>		22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5-21-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		25a. REC'D BY REGISTRAR <b>MAY 24 '60</b>	
ADDRESS <b>5305 Harford Rd</b>		25b. REGISTRAR'S SIGNATURE <i>Charles E. Hume</i>	





may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

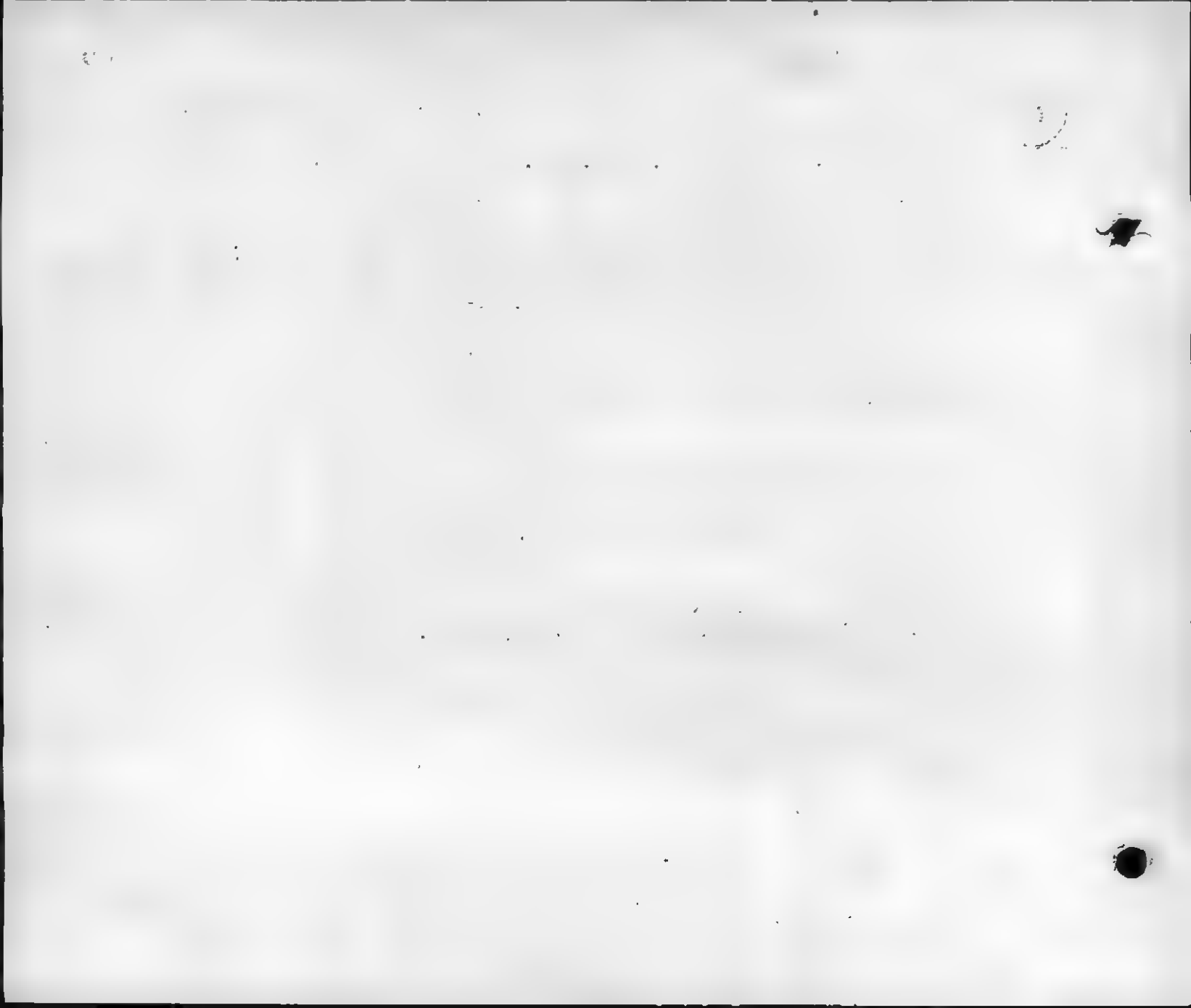
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5649

CERTIFICATE OF DEATH

05623

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived) If institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE, MD.</b>				c. LENGTH OF STAY IN 1b <b>1yr. 10mo. 11da.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRINGFIELD STATE HOSPITAL</b>				e. STREET ADDRESS <b>2760 TIVOLY AVE.</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELIZABETH</b> Last <b>MERZ</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>22</b> Year <b>19 60</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-14-87</b>	9. AGE (In years last birthday) <b>72</b> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>U.S.A. Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>JOHN ZIMMER</b>			
14. MOTHER'S MAIDEN NAME <b>MARGARET ?</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO				17. INFORMANT Address <b>SPRINGFIELD HOSPITAL RECORDS, SYKESVILLE, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONITIS</b> <b>4/24/61</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>CHRONIC CONGESTIVE HEART FAILURE</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>MONTH</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FRACURE LEFT FEMUR</b> <b>C.B.S. cerebral arteriosclerosis with psychosis.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>4/25</b> 19 <b>60</b> to <b>5/22</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>5/22/</b> 19 <b>60</b> , and that death occurred at <b>7 A.</b> M. from the causes and on the date stated above							
22a. SIGNATURE <b>Heinz H. Klaatsch</b> M.D.				22b. DATE SIGNED <b>5/22/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>HEINZ H. KLAATSCH</b>				22d. ADDRESS <b>SYKESVILLE, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>5/27/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard Ruck</b>				25a. REC'D BY REGISTRAR <b>5305 Harbor Rd</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

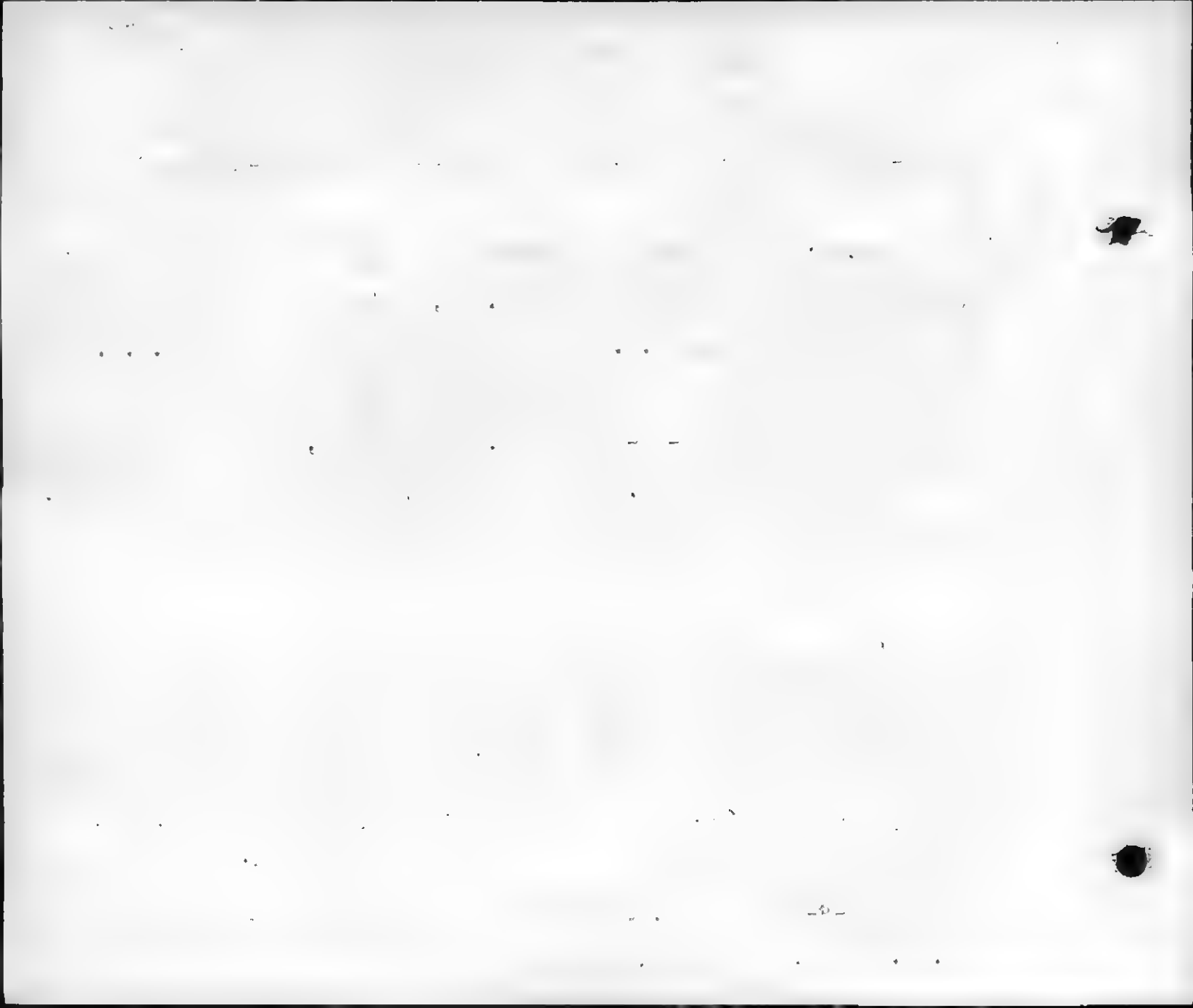
05624

5650

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institut on Residence before admiss.on) a STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Westminster</b>		c. LENGTH OF STAY IN 1b <b>15 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At Winfield</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>ANDREW</b> First <b>GUY</b> Middle <b>MUMFORD</b> Last		4. DATE OF DEATH <b>May</b> Month <b>5</b> Day <b>1960</b> Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11, 1879</b>
9. AGE (In years last birthday) <b>80</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Mumford</b>		14. MOTHER'S MAIDEN NAME <b>Mary Long</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <b>*****</b>		16. SOCIAL SECURITY NO. <b>705-12-3842</b>	
INFORMANT <b>Mrs. Maud Duvall,</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate</b> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>about 4yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 1950</b> to <b>May 1960</b> , that I last saw the deceased alive on <b>May 4</b> 19 <b>60</b> , and that death occurred at <b>1225 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W.B. Culwell</b> M.D.		ADDRESS (Street, city or town, state) <b>900 So main</b> DATE SIGNED <b>5/5/60</b>	
PHYSICIAN'S NAME (Type) <b>W.B. Culwell</b>		<b>Mt. Airy, Md</b>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-8-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. James Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Carroll, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	



5651

CERTIFICATE OF DEATH

05625

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH <input checked="" type="checkbox"/> COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hampstead Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>321 N. MAIN ST</u>		d. STREET ADDRESS <u>321 N. MAIN ST</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Phillip</u> Last <u>Myers</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 25, 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Thomas Myers</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ann Algie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service. <u>no</u>		16. SOCIAL SECURITY NO. <u>215-07-4799</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Coronary Occlusion</u> (c) <u>Arteriosclerotic Cardio Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
18. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		19. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20d. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>48</u> , to <u>May 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 24</u> , 19 <u>60</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		DATE SIGNED <u>7/25/60</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		<u>Hampstead Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-28/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. Chipton</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 31 '60</u>	
ADDRESS <u>Hampstead Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

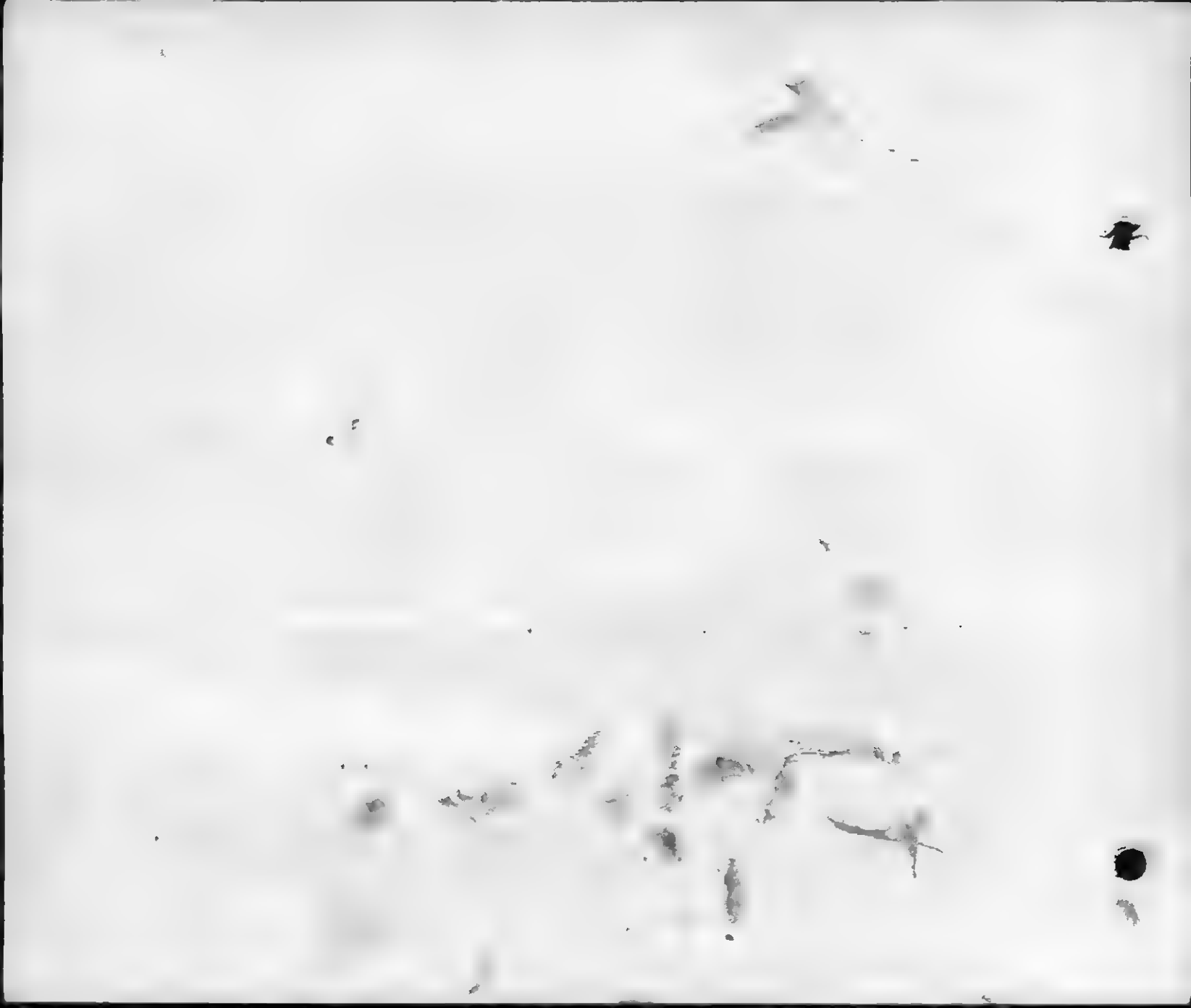


**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**5652** **CERTIFICATE OF DEATH**

05626

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>			c. LENGTH OF STAY IN 1b <b>30 years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>?</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>-</b> Last <b>Neenan</b>				4. DATE OF DEATH Month <b>5</b> Day <b>24</b> Year <b>19 60</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>?</b>		9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Springfield Hospital Records, Sykesville</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>Coronary occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Schizophrenic Reaction, Paranoid Type.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>  <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>I</del> (this hospital) attended the deceased from <b>12/4/1928</b> to <b>5/24/1960</b> , that <del>I</del> (we) last saw the deceased alive on <b>5/24/1960</b> , and that death occurred at <b>3:15 P.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Rita S. Glahn</b> M.D.				22b. DATE <b>May 24, 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>Rita S. Glahn, M. D.</b>				22d. ADDRESS <b>Springfield State Hosp. Sykesville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>May 26 - 1960</b>		<b>May 26 - 1960</b>		<b>Baltimore Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>James H. + ...</b>				25a. REC'D BY REGISTRAR <b>MAY 27 60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

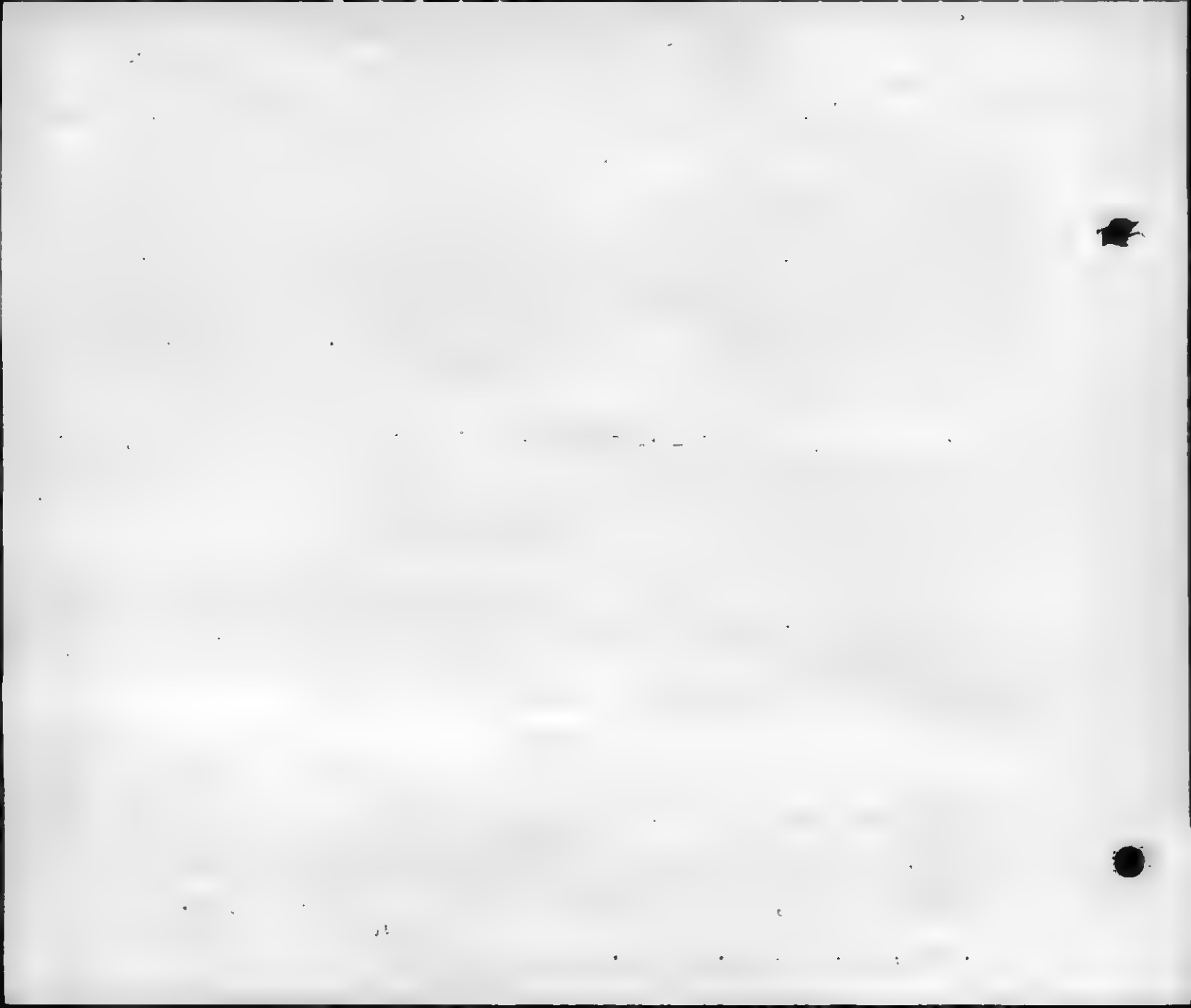




1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
5653 CERTIFICATE OF DEATH

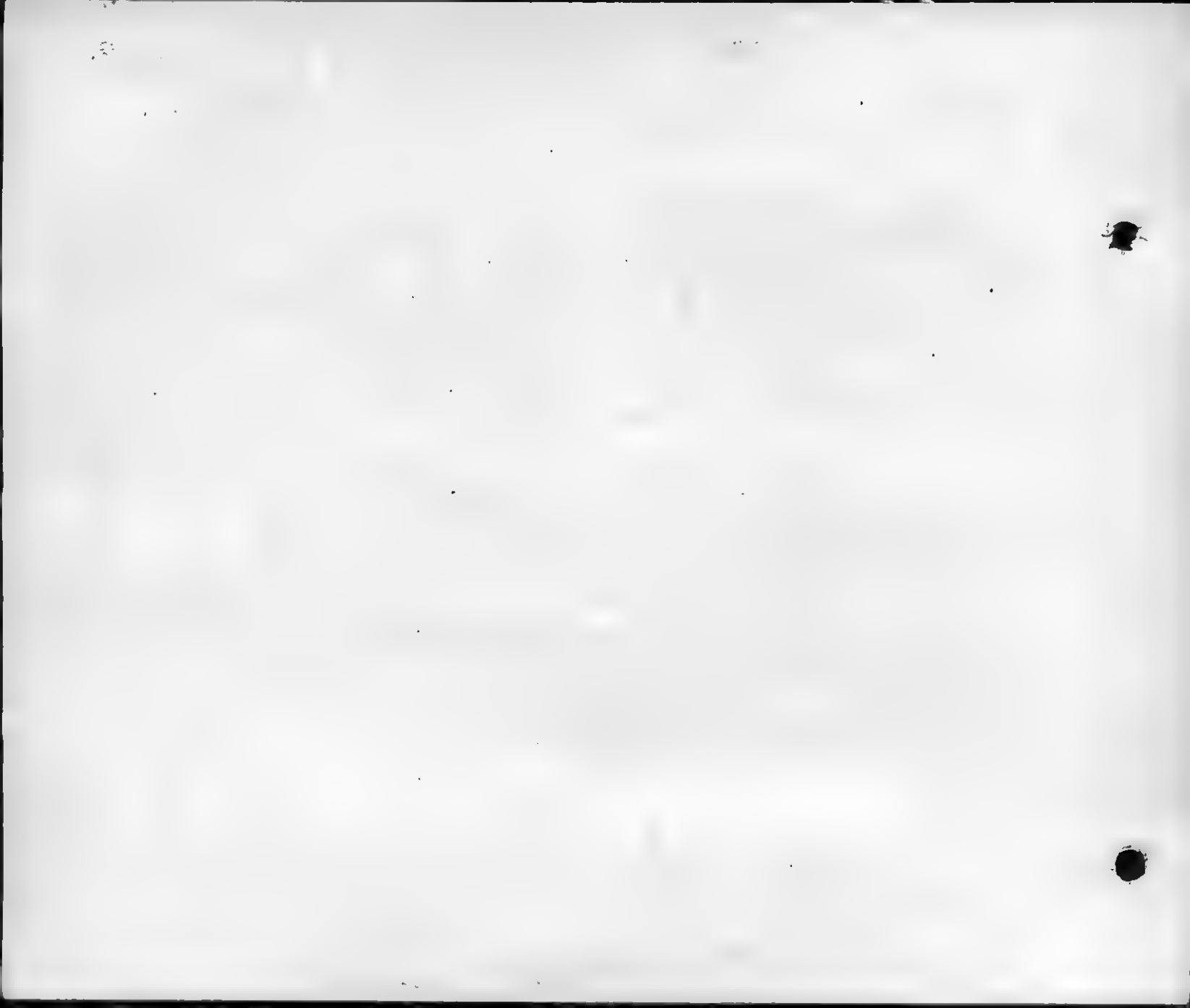
05627

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE, Md.</b>		c. LENGTH OF STAY IN 1b <b>5 Yrs, 6 mts, 13 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRINGFIELD STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>VERA</b> Middle <b>URSULA</b> Last <b>PAYNE</b>		4. DATE OF DEATH Month <b>5</b> Day <b>7</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-29-95</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR: Months <b>7</b> Days <b>7</b> Hours <b>1</b> Min. <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DEER ISLAND, New Brunswick CANADA</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK Whalen</b>		14. MOTHER'S MAIDEN NAME <b>Suzie PARKER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>190-18-0772</b>	
17. INFORMANT <b>SPRINGFIELD STATE HOSPITAL, MARYLAND</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>Acute heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC BRAIN SYNDROME ASSOCIATED WITH DISEASE OF UNKNOWN OR UNCERTAIN CAUSE, Chronic BRAIN SYNDROME OF UNKNOWN OR UNSPECIFIED CAUSE, HUNTINGTON'S CHorea with</b> 19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Psychotic Reaction.</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-25-1960</b> to <b>5-7-1960</b> that (I) (we) last saw the deceased alive on <b>5-7-1960</b> and that death occurred at <b>8 AM</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>Regentia del Campo</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>May 9, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc.</b>		25a. REC'D BY REGISTRAR <b>MAY 10 '60</b>	
ADDRESS <b>1217 St. Paul St.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	



1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
5654  
CERTIFICATE OF DEATH  
05628

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE, MD.</b> c. LENGTH OF STAY IN 1b <b>7 months 12 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>516 SUSSEX Rd. 1</b>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>MORGAN</b> Last <b>PRINCE</b>		4. DATE OF DEATH Month <b>5</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-20-80</b>
9. AGE (In years lost birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD TRIPPETT MORGAN</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH ANN FRENCH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>SPRINGFIELD STATE HOSPITAL, MARYLAND.</b>	
17. INFORMANT <b>SPRINGFIELD STATE HOSPITAL, MARYLAND.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>ARTERIO-SCLEROTIC HEART DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>GENERALIZED ARTERIO-SCLEROSIS</b> DUE TO (c) <b>CHRONIC BRAIN SYNDROME ASSOCIATED WITH CEREBRAL ARTERIO-SCLEROSIS WITH PSYCHOTIC REACTION</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome Associated with Cerebral arteriosclerosis with</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>PSYCHOTIC REACTION</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>SPRINGFIELD STATE HOSPITAL, MARYLAND.</b>	
20e. (City or town) <b>BALTIMORE</b>		20f. (County) <b>BALTIMORE</b> (State) <b>MARYLAND</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 12, 1960</b> to <b>May 6, 1960</b> , that (I) (we) last saw the deceased alive on <b>MAY 6, 1960</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE SIGNED <b>MAY 10 '60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo</b>		22d. ADDRESS <b>4905 York Rd Baltimore</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-12-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHN'S-HUNTINGDON</b>		23d. LOCATION (City, town, or county) <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins</b>		25. REC'D BY REGISTRAR <b>DATE MAY 10 '60</b>	
25. REGISTRAR'S SIGNATURE <b>Carlton S. Hines</b>		26. REGISTRAR'S SIGNATURE	



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

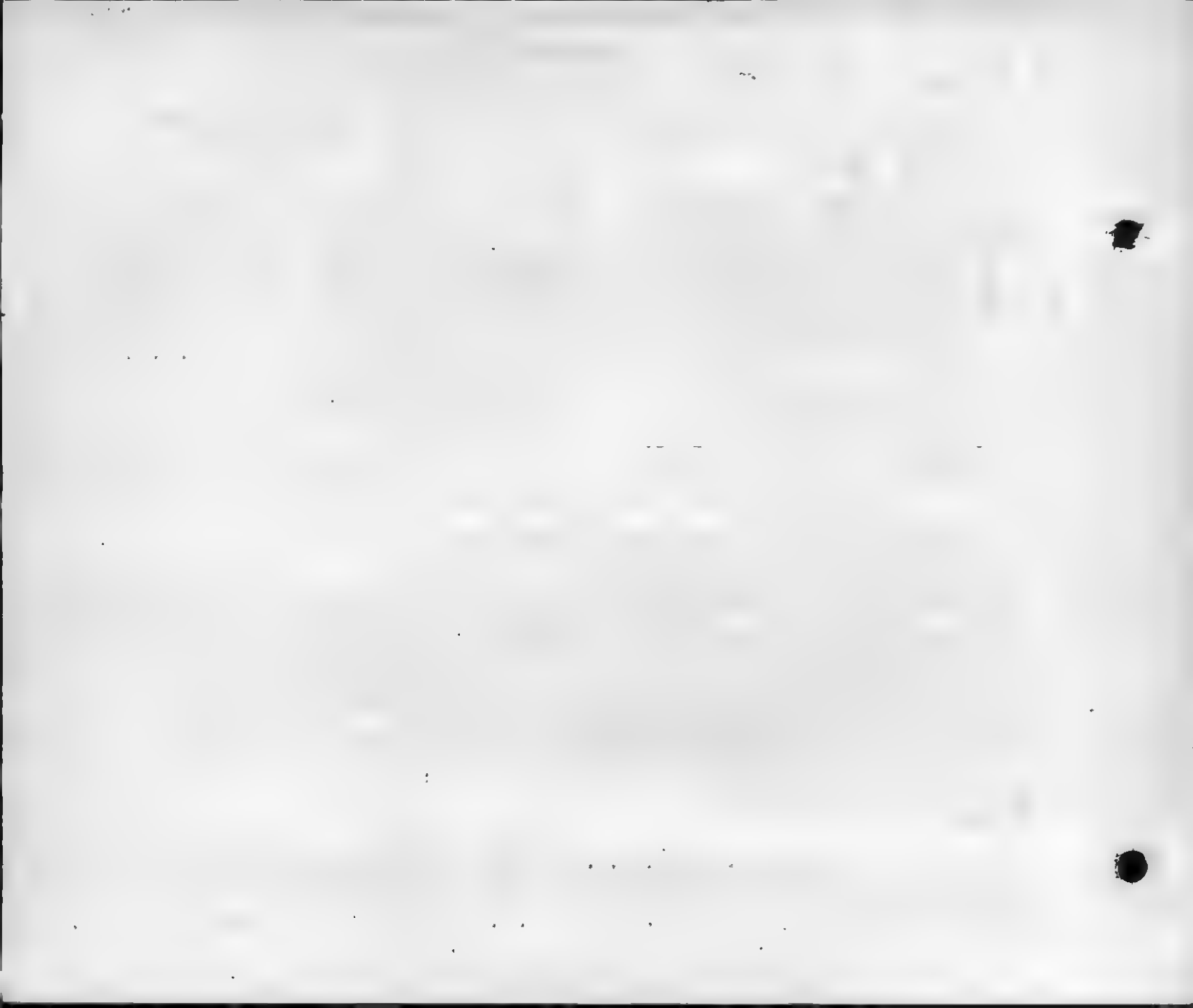
5655  
CERTIFICATE OF DEATH

05629

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SMITHSBURG</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRINGFIELD STATE HOSPITAL</b>		d. STREET ADDRESS <b>Route # 1</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JENNIE MAUDE PRYOR</b>		4. DATE OF DEATH Month Day Year <b>5 26 1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/8/78</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Emmanuel Pryor</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Shuff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial degeneration</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS associated with cerebral arteriosclerosis, with psychotic reaction</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/28/60</b> , 19____, to <b>5/26/60</b> , 19____, that I last saw the deceased alive on <b>5/26/60</b> , 19____, and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Gertrude M. Gross, M.D.</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Gertrude M. Gross, M.D.</b>		<b>Springfield State Hospital</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 29, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Bethel M.E. (Garfield)</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Btl Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bitts</b>		24a. REC'D BY REGISTRAR <b>May 31 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be signed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
 1  
 5656  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

05630

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stebenville</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stebenville</u>		d. STREET ADDRESS <u>16 Garden Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Bascom</u> Last <u>Richardson</u>				4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. DATE OF BIRTH <u>June 5, 1910</u>	9. AGE (In years last birthday) <u>49</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical</u>		11. BIRTHPLACE (State or foreign country) <u>Amherst Co, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel P. Richardson</u>				14. MOTHER'S MAIDEN NAME <u>Synda Packer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>160-16-4765</u>		17. INFORMANT <u>Mr. George Richardson - Stebenville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest, Coronary</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>1959</u> <u>11 May 1960</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>11 May</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11 May 1960</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Howard E. Hall</u>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>11 May 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>				22d. ADDRESS <u>Agnewville, Md</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 14, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		23d. LOCATION (City, town or county) (State) <u>Stebenville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Haight, Stebenville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 18 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u>	





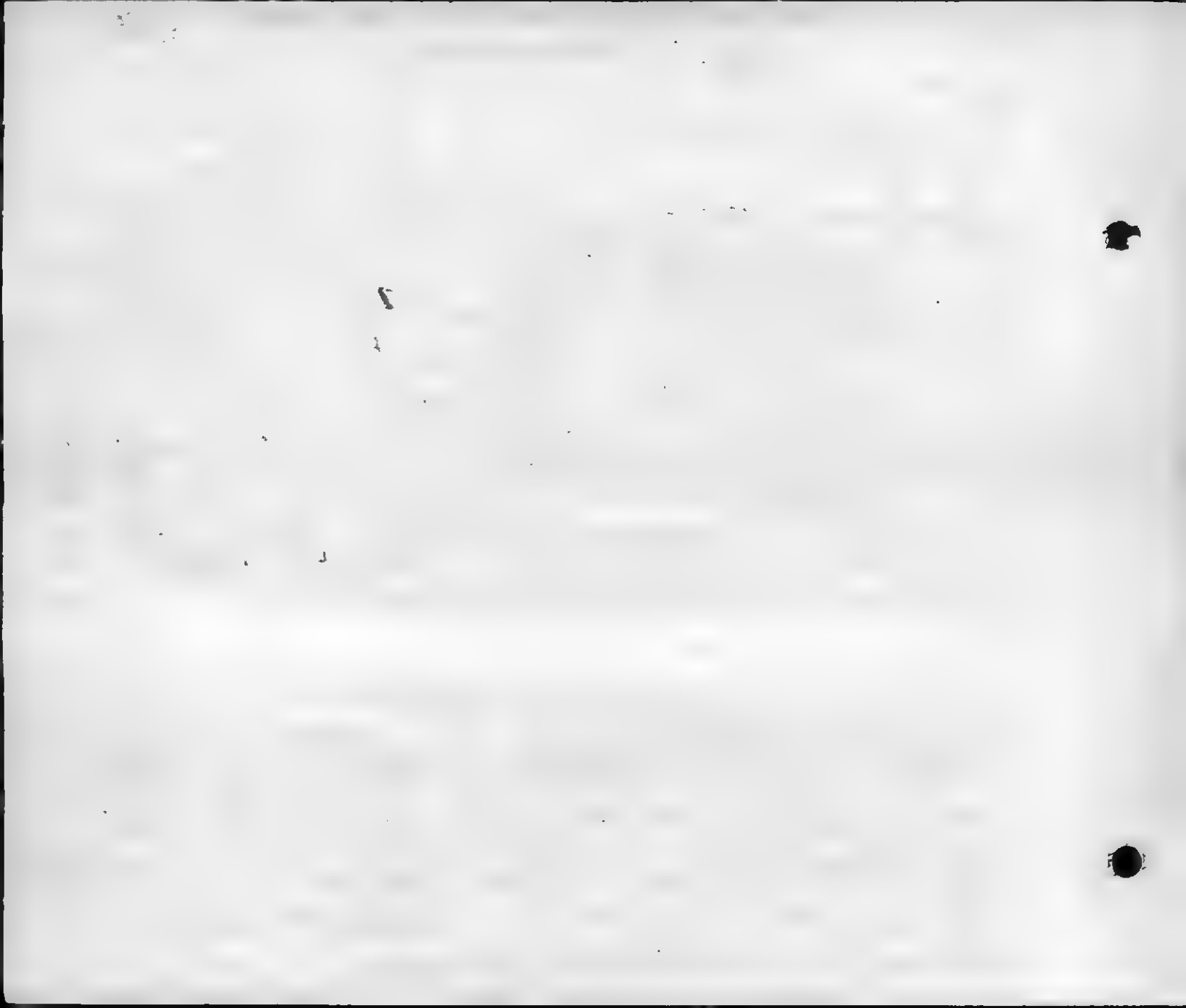
## CERTIFICATE OF DEATH

Reg. Dist. No.

5620

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>	
c. LENGTH OF STAY IN 1b <b>14 YEARS</b>		d. STREET ADDRESS <b>8 MILTON AVE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 MILTON AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LENA</b> Last <b>GALLANT ROSENSTOCK</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 3 1887</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>LAZOR GALLANT</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MILTON ROSENSTOCK</b>		Address <b>WESTMINSTER</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> 13 YEARS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIO-CEREBRAL VASCULAR DISEASE</b> 45 YEARS DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>SEPT 1958</b> to <b>MAY 1 1960</b> , that I last saw the deceased alive on <b>APRIL 30 1960</b> , and that death occurred at <b>2:40 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>19 RIDGE ROAD</b> DATE SIGNED <b>5/1/60</b> ACTUAL SIGNATURE <b>Daniel I. Welliver</b> M.D. PHYSICIAN'S NAME (Type) <b>DANIEL IRVIN WELIVER WESTMINSTER MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/2/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Hebrew</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>SOL LEVINSON &amp; BROS INC</b>		24a. REC'D BY REGISTRAR <b>6010 Reisterstown Rd Baltimore</b>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

05632

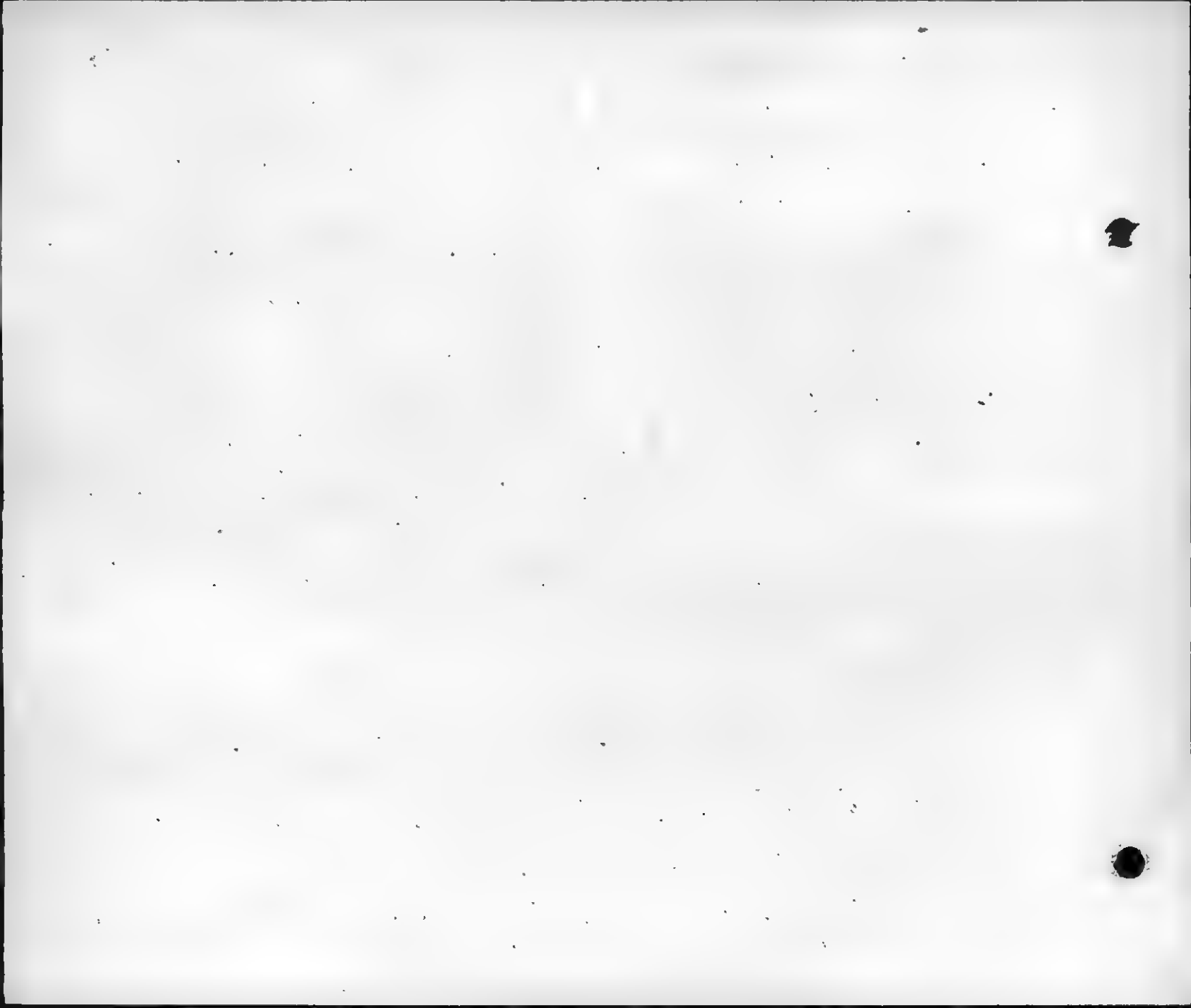
Reg. Dist. No.

5657

1. PLACE OF DEATH: a. COUNTY <u>Annol</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Supersville Rural</u>		c. LENGTH OF STAY IN 1b <u>1 wk</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>		d. STREET ADDRESS <u>Rural</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Eora</u> Middle <u>E</u> Last <u>Ruby</u>		4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12-1873</u>
9. AGE (In years last birthday) <u>86</u>		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months <u>8</u> Days <u>6</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Chas. Alas</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Therit</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or (unknown)) <u>No</u>		16. SOCIAL SECURITY NO <u>NO</u>	
17. INFORMANT <u>Mrs. Wm. Wheeler</u>		Address <u>Parkton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>hypertension</u> DUE TO (c) <u>arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 yr</u> <u>10 yr</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 27, 1960</u> to <u>May 4, 1960</u> , that I last saw the deceased alive on <u>May 4, 1960</u> , and that death occurred at <u>10</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>By the side of the road</u> DATE SIGNED <u>May 10 1960</u>			
ACTUAL SIGNATURE <u>Dr. Wm. Wheeler</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Wm. Wheeler</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 7/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Grace Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. D. Dutton</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>	
ADDRESS <u>Hampstead Md</u>		DATE <u>MAY 10 1960</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar's office within 72 hours after death, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

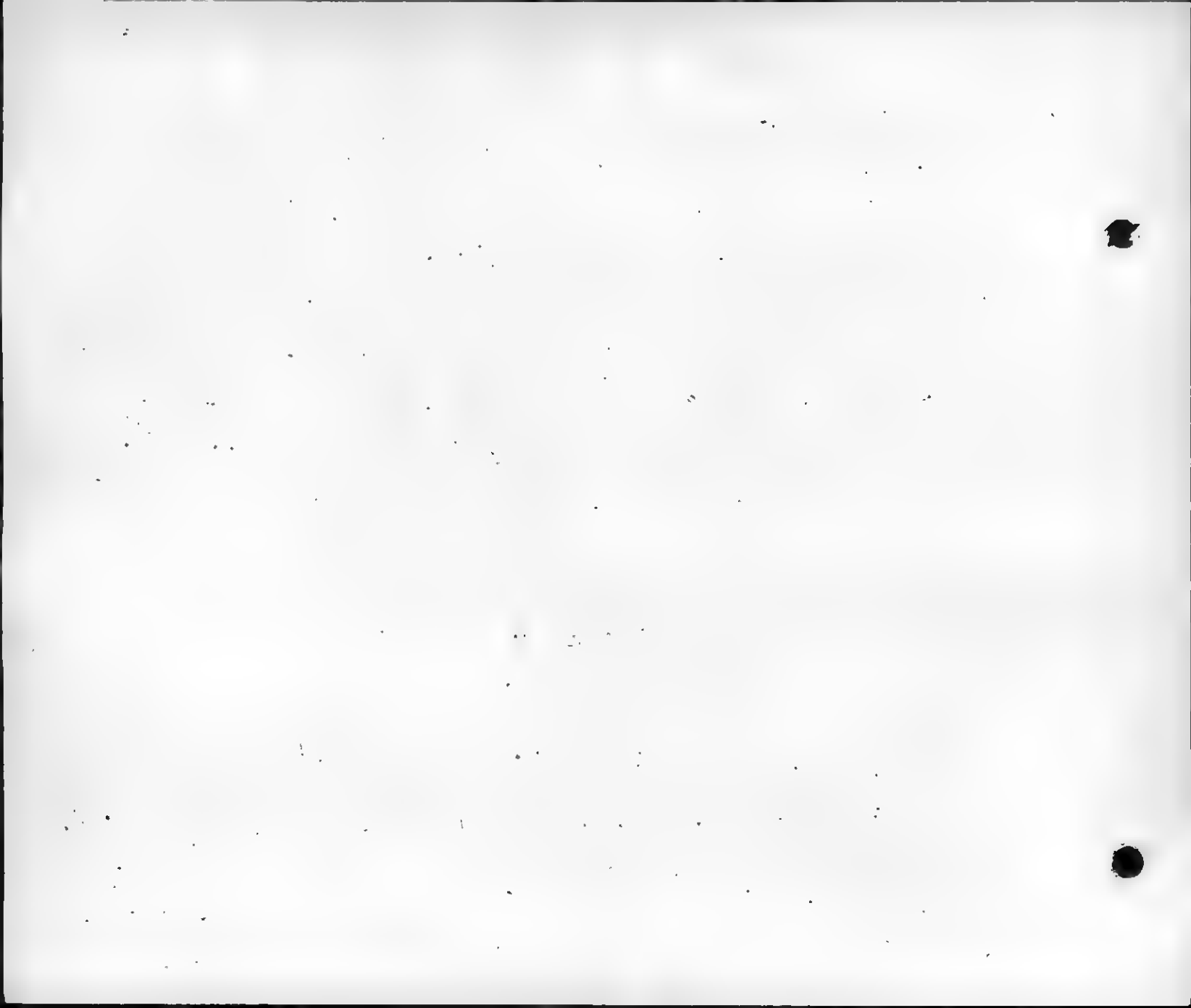
5658

CERTIFICATE OF DEATH

05633  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carmel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carmel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster 67000</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12 Fairview</u>				e. STREET ADDRESS <u>12 Fairview</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY CORNELIUS SNYDER</u>				4. DATE OF DEATH Month Day Year <u>MAY 10 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 29, 1915</u> 45 yrs	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Club</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General store</u>		11. BIRTHPLACE (State or foreign country) <u>Westminster, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert H. Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Adie May Shipley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO <u>213-05-1623</u>		INFORMANT Address <u>Mrs H.C. Snyder Westminster, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of liver</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of liver</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 22, 1960</u> to <u>May 10, 1960</u> that I last saw the deceased alive on <u>May 9, 1960</u> , and that death occurred at <u>5:45 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 Kemper av. 510/60</u> (DATE SIGNED) ACTUAL SIGNATURE <u>G. Reese Wilkens</u> M.D. PHYSICIAN'S NAME (Type) <u>E. REESE WILKENS</u> <u>Westminster</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/13/60</u>		<u>Westminster Branch</u>		<u>Rural Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>5000 J. P. Westminster, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 16 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

T HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1  
 may be signed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

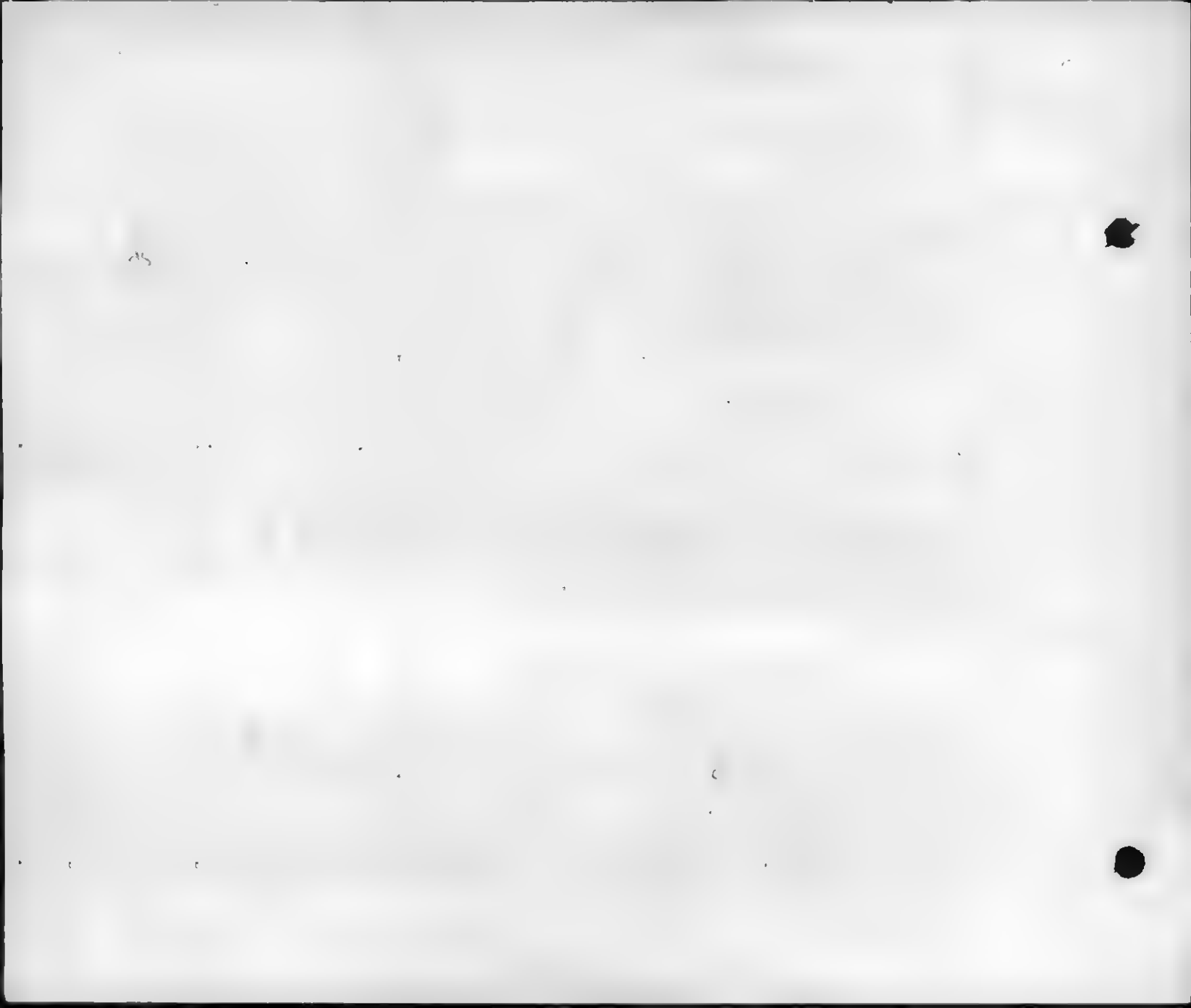
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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5659

05634

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>				c. LENGTH OF STAY IN 1b <b>16 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
				d. STREET ADDRESS <b>1933 West Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Edward</b> Last <b>Spriggs</b>				4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-8-1896</b>	
9. AGE (In years lost birthday) <b>63</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>6</b> Days <b>3</b> Hours <b>0</b> Min. <b>0</b>					
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Parole, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Samuel Spriggs</b>				14. MOTHER'S MAIDEN NAME <b>Frances Carpenter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>212-12-6356</b>		17. INFORMANT <b>Gladys Simms - 1933 West St., Annapolis, Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Malnutrition due to extensive pyorrhea</b> DUE TO (c) <b>Pulmonary tbc. and Spondyloarthrosis of spine</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 16</b> 19 <b>60</b> , to <b>May 26</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>May 26</b> 19 <b>60</b> , and that death occurred on <b>11.50 am</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Edgars M. Maculans</b> M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>May 26, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans</b>				22d. ADDRESS <b>Henryton State Hospital, Henryton, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>5-24-1960</b>		<b>Birwood Hall</b>		<b>ANNAPOLIS MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Reed</b>				25a. RECEIVED BY REGISTRAR <b>MAY 31 1960</b>		25b. REGISTRAR'S SIGNATURE <b>William Reed</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05635

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b> <b>11X-2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>30 Alder Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Thomas</b> Last <b>Stark</b>				4. DATE OF DEATH Month <b>May</b> Day <b>25</b> , Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 16, 1921</b>		9. AGE (In years last birthday) <b>38</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Theatre Bldg.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>L. Henry Stark</b>				14. MOTHER'S MAIDEN NAME <b>Lula Stewart</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-16-4162</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pending further pathology studies</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Barbiturate Withdrawal Syndrome</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Slipped on shower room floor, striking head &amp; back on shower.</b>					
20c. TIME OF INJURY Month, Day, Year <b>3:00 P.M. 5/23/ 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Sykesville Carroll Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James T. Marsh, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>				DATE SIGNED <b>5/25/60</b>			
22a. BURIAL-CREMATATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/28/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oakland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Reighton</b>				ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 27 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

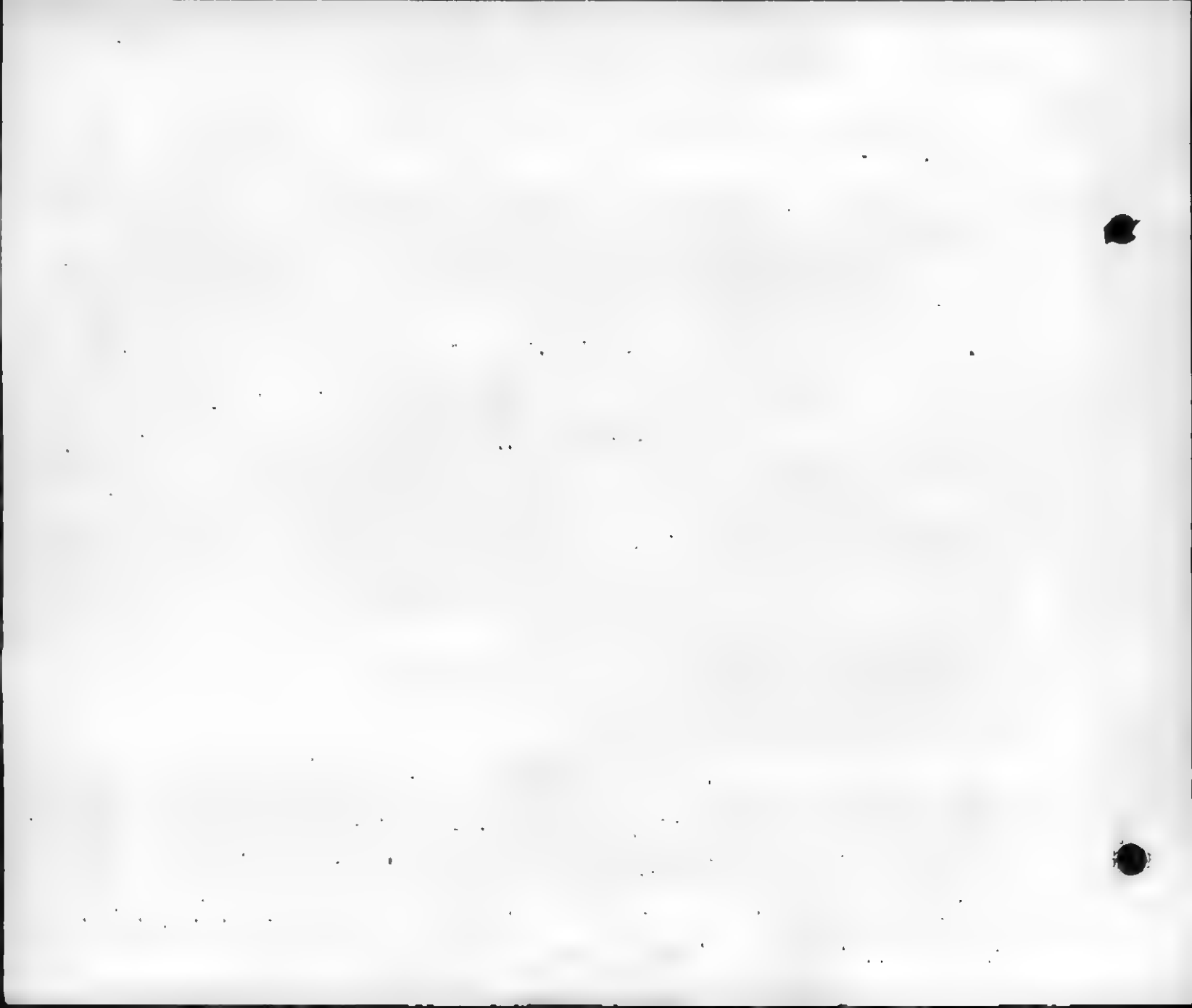
5661

## CERTIFICATE OF DEATH

05636  
Reg. Dist. No.

<b>1 PLACE OF DEATH</b> a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TANEY TOWN</u> c. LENGTH OF STAY IN 1b <u>2 YEARS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>32 FREDERICK ST.</u>				<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>134 ROSSUTH ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3 NAME OF DECEASED</b> (Type or print) First Middle Last <u>GEORGE JAMES STRICKER</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>MAY 27 1960</u>			
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>FEB 4, 1876</u>	
<b>9. AGE</b> (In years last birthday) yrs. <u>84</u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>CLOTHING MFR</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>BALTIMORE Md.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		<b>13. FATHER'S NAME</b> <u>ANTON STRICKER</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>MARGARET KOERNER</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)	
<b>16. SOCIAL SECURITY NO.</b> <u>216-05-9805</u>		<b>INFORMANT</b> <u>Mrs. Joseph Wiedeck, 524 Academy Rd</u>		<b>18 CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic myocardial</u> <u>432.1</u> DUE TO (b) <u>Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part I of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. _____ 19 _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>March 6 1960</u> , to <u>May 26 1960</u> , that I last saw the deceased alive on <u>May 26, 1960</u> , and that death occurred at <u>1 A. M.</u> from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <u>J. H. LEGG M.D.</u>		<b>ADDRESS</b> (Street, city or town, state) <u>Union Bridge Md.</u>		<b>DATE SIGNED</b> <u>5-27-60</u>		<b>PHYSICIAN'S NAME (Type)</b> <u>J. H. LEGG M.D.</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>5/30/60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Holy Cross Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Brooklyn A.A. Co. Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Leonard J. Ruck 5305 Harford Road #14</u>				<b>24a. REC'D BY REGISTRAR</b> <u>MAY 31 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



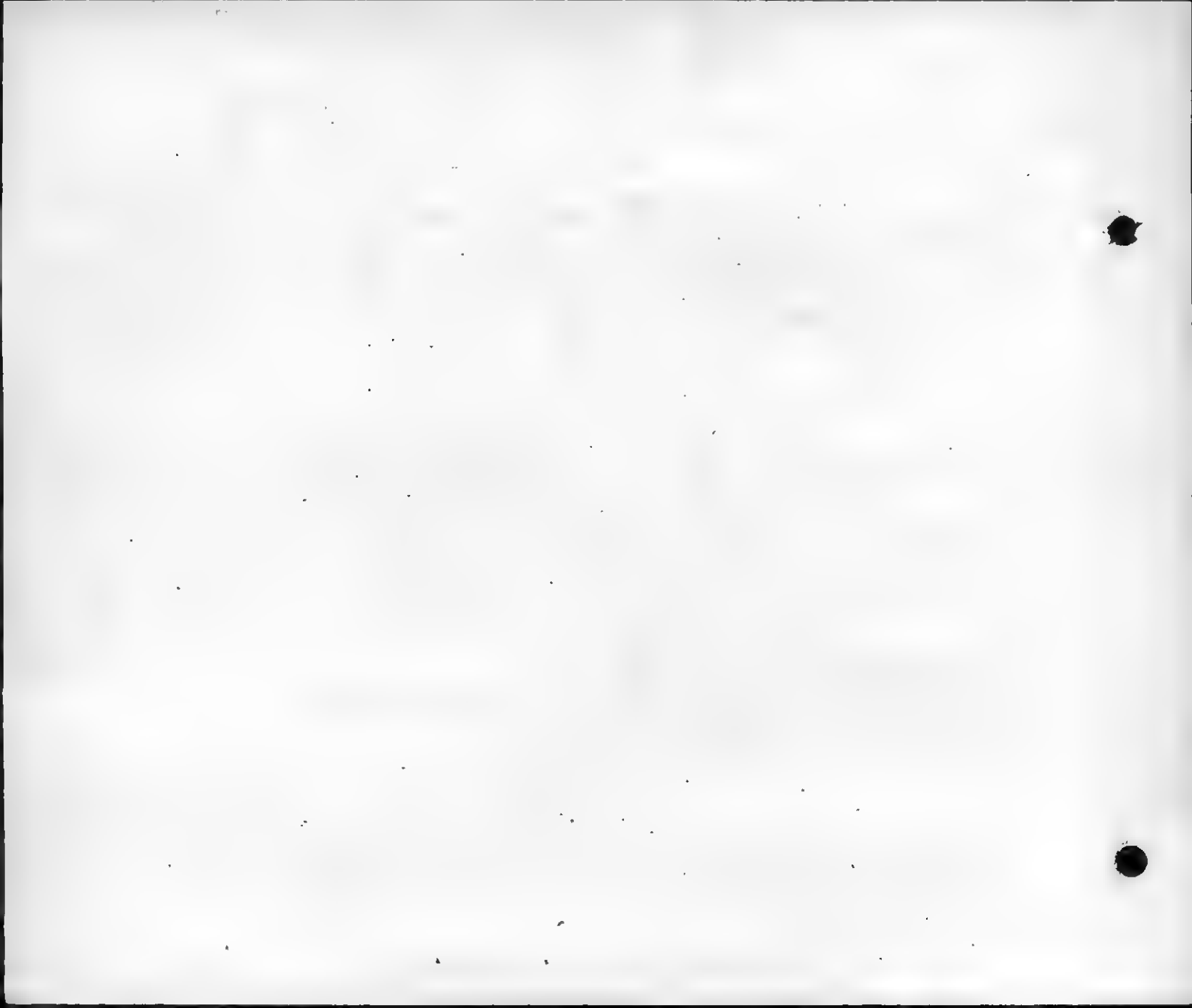
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5621

CERTIFICATE OF DEATH

Reg. Dist. No. 05637

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>58 CHARLES ST</u>				d. STREET ADDRESS <u>58 CHARLES ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CORA</u> First <u>IRENE</u> Middle <u>TUCKER</u> Last				4. DATE OF DEATH Month <u>MAY</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 19-1888</u>	9. AGE (In years last birthday) <u>71</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THEODORE DORSEY</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET JONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>212-40-5239</u>		INFORMANT <u>MRS MARGIE CLARK WESTMINSTER</u>		Address <u>MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ast. (b) <u>Coronary Sclerosis</u> DUE TO <u>Hypertension &amp; Arteriosclerosis</u> (c) <u>Coronary Sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>5-7 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 9</u> , 19 <u>60</u> , to <u>May 9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 9</u> , 19 <u>60</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W Glenn Speicher</u>				ADDRESS (Street, city or town, state) <u>Westminster Md</u>			
PHYSICIAN'S NAME (Type) <u>W GLENN SPEICHER</u>				DATE SIGNED <u>5/9/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W Hartzler &amp; Sons Union Bridge Md</u>				24a. REC'D BY REGISTRAR <u>May 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Kneiss</u>	



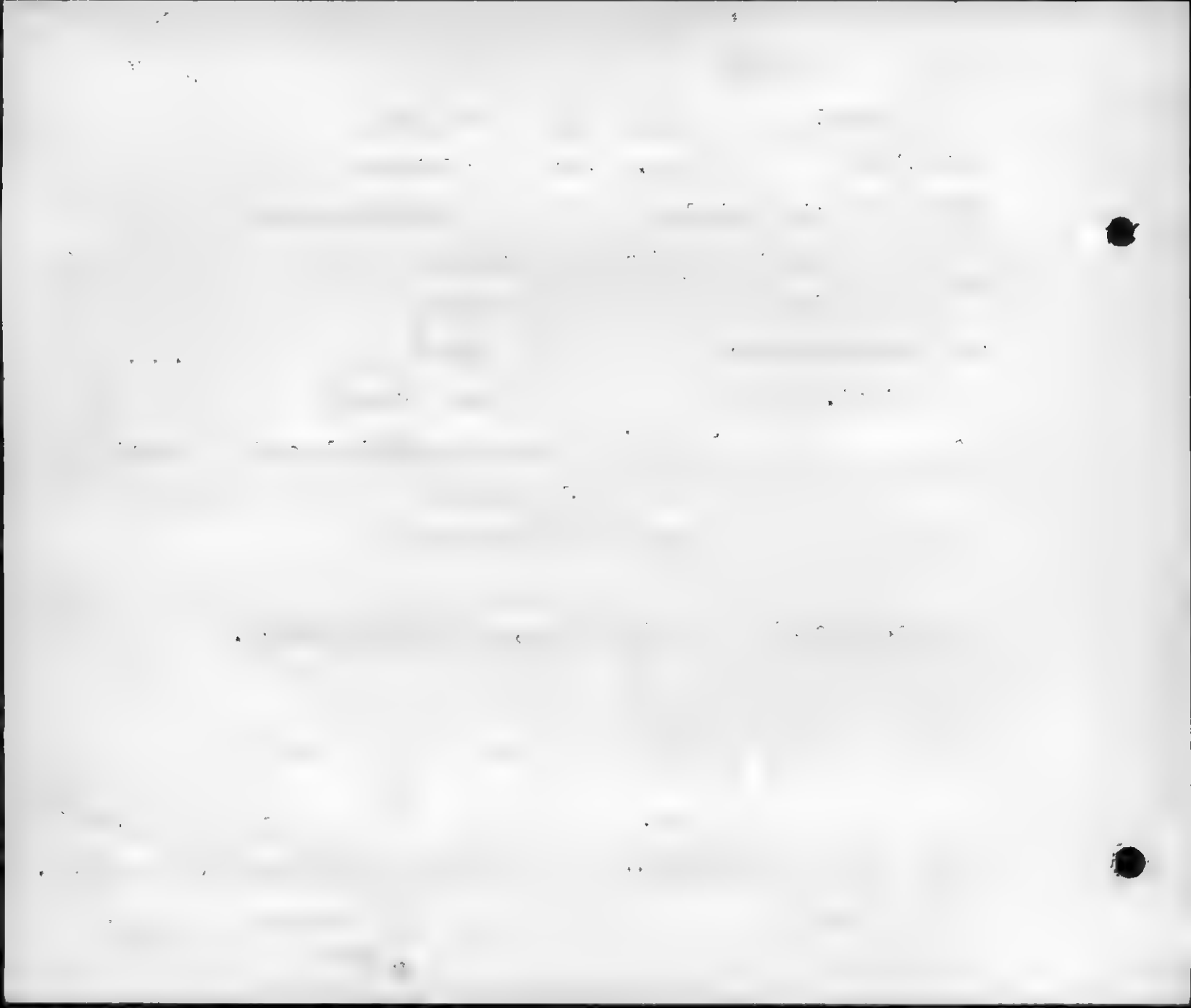
may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

1 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
5662 CERTIFICATE OF DEATH

05638

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b <b>2 mos. 5 days</b>				d. STREET ADDRESS <b>632 Colorado Avenue</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Grinstead</b> Last <b>Vaughan</b>				4. DATE OF DEATH Month <b>5</b> Day <b>21</b> Year <b>1960</b>			
5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/7/83</b>	
9 AGE (In years last birthday) <b>76</b> yrs		IF UNDER 1 YEAR Months <b>21</b> Days <b>21</b> Hours <b>00</b> Min <b>00</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Business Administrator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kentucky</b>	
11 BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William M. Vaughan</b>		14. MOTHER'S MAIDEN NAME <b>Angie Grinstead</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-03-0666</b>		17. INFORMANT <b>Springfield Hospital Records</b>		Address <b>Sykesville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Occlusion Left Coronary Artery</b> DUE TO (c) <b>GBS assoc. With cerebral arteriosclerosis, with Psychotic reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Day</b> <b>Day</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>GBS assoc. With cerebral arteriosclerosis, with Psychotic reaction.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 30, 1960</b> , to <b>May 21, 1960</b> , that (I) (we) last saw the deceased alive on <b>May 21, 1960</b> , and that death occurred at <b>9A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Agustin del Campo</i> 22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5/21/60</b>	
22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-23-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City, town, or county) (State) <b>Pikesville Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins &amp; Sons Co.</i>				ADDRESS <b>4905 York Rd.</b>		25a. REC'D BY REGISTRAR DATE <b>5/23/60</b>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur A. [illegible]</i>			



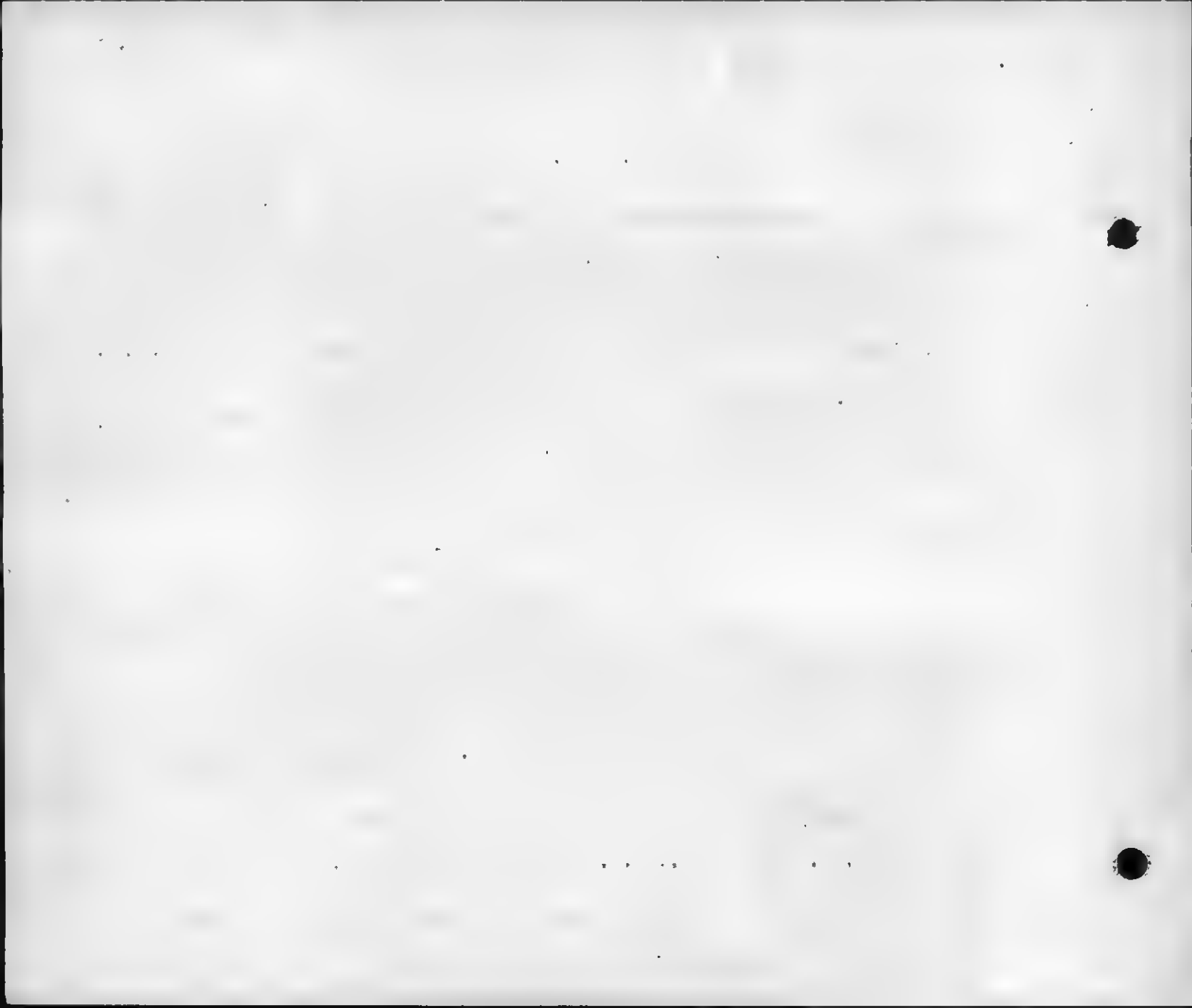


may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
5663 CERTIFICATE OF DEATH

05639

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2 yr. 6 mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Grand View Convalescent Home</b>				e. STREET ADDRESS <b>912 Belvedere Avenue</b>			
3 NAME OF DECEASED (Type or print) <b>Laura Prevost McCarty Whiteford</b>				4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 12, 1875</b>	9. AGE (In years last birthday) <b>84</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Payton L. McCarty</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Walker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>912 Belvedere Avenue Balto. 10 W. Hamilton Whiteford</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EMBOLISM, PULMONARY, DUE TO CIRCULATORY DISTURBANCE</b> DUE TO <b>442X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Cardiovascular disease with hypertension; Arteriosclerotic Heart disease 20 plus yrs.</b> (c) <b>Advanced Senile Changes</b>							INTERVAL BETWEEN ONSET AND DEATH <b>20 MIN.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVING RISE TO PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>22 Sept. 1957</b> to <b>3 May 1960</b> , that (I) (we) last saw the deceased alive on <b>3 May 1960</b> , and that death occurred at <b>4:30 P.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm. H. Lawson, Jr., M.D.</b>				22b. DATE SIGNED <b>5/3/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Wm. H. Lawson, Jr., M.D.</b>	
22d. ADDRESS <b>Sykesville, Maryland</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					
23b. DATE THEREOF <b>May 5, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry Sander &amp; Sons Inc.</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 6 '60</b>		25b. REGISTRAR'S SIGNATURE <b>C. L. S. Thomas</b>	
25c. ADDRESS <b>Baltimore 13, Maryland</b>							



5664

## CERTIFICATE OF DEATH

Reg. Dist. No. 05640

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		c. LENGTH OF STAY IN 1b <u>65 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Westminster RD#4</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>(Mexico) RD#4</u>				d. STREET ADDRESS <u>1 (Mexico)</u>			
3. NAME OF DECEASED (Type or print) <u>EMMA</u> First <u>HELEN</u> Middle <u>WIKE</u> Last				4. DATE OF DEATH Month <u>MAY</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8, 1874</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Md. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Autz</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Henry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>Mrs Mary Housifer</u>		Address <u>Westminster, Md. RD#4</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>5 yrs</u> (c) <u>Hypertension</u> DUE TO <u>5 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July</u> 19 <u>52</u> to <u>May 10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 9</u> , 19 <u>60</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>W. H. Foard</u> DATE SIGNED <u>5/10/60</u> ACTUAL SIGNATURE <u>W. H. Foard M.D.</u> ADDRESS <u>Manchester, Md.</u> PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u> ADDRESS <u>Manchester, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/13/60</u>		<u>Leisters Cemetery</u>		<u>Rural Westminster Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers</u>				ADDRESS <u>Westminster, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Harris</u>	
				DATE <u>MAY 10 1960</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

RECEIVED

1903

5665

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>221 Beckleysville Rd.</u>				d. STREET ADDRESS <u>221 Beckleysville Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Melchoir</u> Last <u>Wisner</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 13, 1885</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Merchandise</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Nelson Wisner</u>				14. MOTHER'S MAIDEN NAME <u>Martha Ellen Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>216-38-3091</u>			
INFORMANT <u>MARY ROWE WISNER</u>				Address <u>HAMPSTEAD MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> 4-22-61 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Diverticulitis of Colon</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 6, 1957</u> , to <u>MAY 7, 1960</u> , that I last saw the deceased alive on <u>MAY 5, 1960</u> , and that death occurred at <u>8:40 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead Md</u>			
DATE SIGNED <u>5/7/60</u>							
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>				<u>HAMPSTEAD MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 9/60</u>		<u>Hampstead</u>		<u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith Clifton</u>				ADDRESS <u>Hampstead Md</u>			
24a. REC'D BY REGISTRAR DATE <u>MAY 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

The first part of the report is a general description of the area. It is a small, flat, open area with a few scattered trees and shrubs. The soil is sandy and the vegetation is sparse. The area is located in the north-east corner of the plot. It is a typical example of a coastal plain. The area is bounded by a low dune on the north and a small stream on the south. The area is a typical example of a coastal plain. The area is bounded by a low dune on the north and a small stream on the south.

The second part of the report is a detailed description of the area. It is a small, flat, open area with a few scattered trees and shrubs. The soil is sandy and the vegetation is sparse. The area is located in the north-east corner of the plot. It is a typical example of a coastal plain. The area is bounded by a low dune on the north and a small stream on the south. The area is a typical example of a coastal plain. The area is bounded by a low dune on the north and a small stream on the south.